Department of Health Services

Gap Analysis and Requirements -

Business Requirements

SD/MC HIPAA Phase II Project

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Final Version

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TABLE OF CONTENTS

INDEX OF TABLES

1. Executive Summary

1.1 Overview

The California Department of Health Services (DHS) has contracted with SAIC and FOX Systems, Inc. (the SAIC/FOX HIPAA Team) to assess the current processes and procedures for Short Doyle/Medi-Cal (SD/MC) claims, to develop a gap analysis highlighting the differences between the current procedures and the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets (TCS) regulations, and to document a set of recommendations that will bring SD/MC into compliance with these requirements. This report details business gaps and requirements as they relate to the HIPAA TCS regulations.

1.2 Executive Summary

The SAIC/FOX HIPAA Team reviewed numerous internal documents, as well as all of the HIPAA assessments conducted to date for DHS, DMH, and ADP. In addition the Team interviewed recommended staff from ADP, DMH, and DHS and attended a county meeting hosted by DHS. From this information the SAIC/FOX HIPAA Team determined the gaps and requirements necessary for HIPAA compliance.

It is important for partners involved in the SD/MC system to decide the covered entity status of their trading partners in order to determine the requirements for HIPAA compliance. Where counties act as health plans, there are different system and transaction requirements than where counties act as providers. These transaction expectations are detailed in this document.

The Team further analyzed the laws and regulations governing the data interchange between SD/MC and its trading partners. Suggestions are made to align these regulations with HIPAA requirements.

The document also details changes necessary to the business environment and to information exchanges to assure that the system will not only be HIPAA compliant, but also that data can be taken into the system, adjudicated properly and returned with payment information in a timely fashion.

Finally, the document presents suggestions regarding how data, available from HIPAA transactions, can be used by a re-engineered system to enhance the information available to programs to improve their business operations, expedite the claiming process, and detect errors or deceptive activities related to claiming. Detailed

recommendations for system changes will be presented in the Recommendations Document.

2. Project Background

The goal of this project is to create a detailed recommendation of the business re-engineering activities, regulation changes, and technical modifications and/or procurements that should be made to make the entire Short-Doyle/Medi-Cal claim process compliant with HIPAA Transactions and Codes Sets (TCS) regulations, while preserving the strategic business and IT plans of the Department of Alcohol and Drug Programs (ADP), DHS, and the Department of Mental Health (DMH). Specifically, the project goal for the SD/MC is to achieve compliance with the HIPAA TCS Final Rule and Addenda. Compliance will require implementing the following transactions:

- ASC X12N 837 (I), Health Care Claim – Institutional, Version 4010A1 (004010X096A1)
- ASC X12N 837 (P), Health Care Claim – Professional, Version 4010A1 (004010X098A1)
- ASC X12N 835, Health Care Claim Payment/Advice, Version 4010A1 (004010X091A1)
- ASC X12N 276/277, Health Care Claim Status Request and Response, Version 4010A1 (004010X093A1)

Full implementation of these transactions and the associated codes sets is expected to require significant business re-engineering.

2.1 Scope

The business areas to be assessed are the program areas using the Short-Doyle/Medi-Cal system. This includes program areas in three departments (DHS, DMH, and ADP):

a. Medi-Cal Specialty Mental Health Services
b. Drug Medi-Cal (DMC)
c. HFP SED benefit claimed through the SD/MC system.

The HIPAA TCS impact upon these programs to be assessed includes the following transactions:

- ASC X12N 837 (I), Health Care Claim – Institutional, Version 4010A1 (004010X096A1)
- ASC X12N 837 (P), Health Care Claim – Professional, Version 4010A1 (004010X098A1)
- ASC X12N 835, Health Care Claim Payment/Advice, Version 4010A1 (004010X091A1)
- ASC X12N 276/277, Health Care Claim Status Request and Response, Version 4010A1 (004010X093A1)

The scope of this engagement also includes the ability to manage these business processes as part of these transactions:

1. The ability to receive the inbound HIPAA transactions as EDI batches.
2. The ability to transmit the outbound HIPAA transactions as EDI batches.
3. The ability to receive and transmit one or more Functional Groups per Interchange Envelope, as defined in Trading Partner Agreements.
4. The ability to manage the HIPAA 837 Claim transactions including:
    a. The ability to take in 837 data and process into the desired format for adjudication
    b. The ability to process claim resubmissions, voids, and replacements
    c. Coordination of benefits between various providers and payers
    d. Claim attachments, if required
    e. Editing and auditing claim data for correctness and validity
5. The ability to manage the HIPAA 835 Claim Payment and Remittance Advice transaction including:
    a. Processing 837 Claim information to create an 835 Remittance Advice
    b. Balancing the transaction at the transaction, claim and service line level
    c. Process adjustments at transaction, claim and service line related to business rules applied by ADP, DHS, and DMH
    d. Enable corrections and reversals
6. Use 837 Claim and 835 Remittance data to receive, process and return 276/277 Claim Status Inquiries and Responses with appropriate information
7. Within the above transactions, receive and process the code sets relevant to the business processes of ADP, DHS, and DMH.
8. Within the above transactions, assess the feasibility of re-engineering the SD/MC system to receive, process, and return the standard transactions.
9. Within the above transactions determine necessary field sizes to accommodate available and relevant data
10. Assessment of current systems and software used manage business processes represented by the above transactions.
11. Assessment of continuation of existing paper processes
12. Assessment of provider assistance such as direct data entry applications.
13. Assessment of supplied laws, regulations and program policies for HIPAA impacts.

2.2 Methodology

In conducting our review, the SAIC/FOX HIPAA Team gathered current project status data by reviewing relevant project documents and interviewing targeted staff and comparing the analysis to HIPAA regulatory criteria. The Team also conducted a review of the Transactions and Code Sets standards identified by the TCS HIPAA Rule and relevant implementation guides for the transactions identified by DHS as part of the scope of this project. Using that analysis as well as substantial HIPAA assessment and

implementation expertise in public agencies, the SAIC/FOX HIPAA Team identified the gaps and requirements necessary to become compliant with the HIPAA TCS rule. The SAIC/FOX HIPAA Team also included details of opportunities where the SD/MC system might enable business process improvements. Documents reviewed are listed in Appendix A of the Assessment Deliverable.

3. Gap Business Functions

3.1 Covered Entity Status

It is highly unlikely that every covered entity under HIPAA has documentation of the covered entity status of its trading partners. In order to determine the requirements for its own compliance, however, each covered entity must either determine or decide the covered entity status of its major trading partners. Since most of the transactions named in the HIPAA TCS rule specify the trading partners that are compelled to conduct business using the standard, the determination of status is the first, and probably most important, step in HIPAA compliance. Most HIPAA named transactions are intended to be exchanged between a provider of health care and a health plan. Other covered entities may choose to use the standard transactions for their business purposes, but that use is not mandated by the HIPAA TCS rule.

In the case of DMH and ADP, it can be argued that the county MHP and AOD programs serve both as providers (because they run facilities or clinics) and as health plans (because they contract with other providers and pay those providers for the health care services). It may be instructive to view this relationship from a slightly different perspective. The DHS Medi-Cal Managed Care Division has a number of contracts with various health plans in the state. Some of those health plans, Kaiser Permanente for example, provide that care directly through their own employees as well as contracting for certain specialty care through other types of providers. Regardless of the mechanism by which these health plans secure the health care in the contract, the Medi-Cal Managed Care Division considers the contractor to be a covered entity health plan under HIPAA. Its relationships and transaction exchanges are those of health plan (Medicaid) to health plan (MCO).

DMH and ADP could alternatively choose to determine that their counties are billing agents or clearinghouses for their subcontracting providers. In this case, the county receives the claim from the provider in a variety of formats, but converts that claim to a standard HIPAA transaction for transmission to DMH or ADP. This decision could include the possibility that the claim transactions are returned to the providers through the counties as clearinghouses/billing agents, or that the county serves as a ‘pay-to’ provider for the claims submitted. Each of these scenarios sets forth a different set of HIPAA transaction requirements for DMH, ADP and the SD/MC system.

3.2 Claim versus Encounter

There is also some controversy regarding the definition of the 837 transaction. The first part of the definition is quite clear:

> (a) A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.[1]

The second part of the definition has caused some controversy:

> (b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.[2]

Some argue that because some managed care organizations pay their providers a salary, that the definition still applies to an exchange of information between a health care provider and a health plan, for health care. Others maintain, that because the trading partners are not specifically named, that the transaction is required between any trading partners that need information about services rendered to patients. Unfortunately, HHS has not addressed this issue with much clarity. The only resource that provides any information is found in the preamble to the original TCS Rule. In this preamble, HHS is defining situations in which standard transactions must be used:

> Example 4: A State Medicaid plan enters into a contract with a managed care organization (MCO) to provide services to Medicaid recipients. That organization in turn contracts with different health care providers to render the services.
>
> A) When a health care provider submits a claim or encounter information electronically to the MCO, is this activity required to be a standard transaction? The entity submitting the information is a health care provider, covered by this rule, and the MCO meets our definition of health plan. The activity is a health care claims or equivalent encounter information designated in this regulation. The transaction must be a standard transaction.
>
> B) The managed care organization then submits a bill to the State Medicaid agency for payment for all the care given to all the persons covered by that MCO for that month under a capitation agreement. Is this a standard transaction? The MCO is a health plan under the

[1] § 162.1101 Health care claims or equivalent encounter information transaction.
[2] § 162.1101 Health care claims or equivalent encounter information transaction, part b.

> definition of "health plan" in § 160.103. The State Medicaid agency is also a covered entity as a health plan. The activity, however, does not meet the definition of a health care claims or equivalent encounter information transaction. It does not need to be a standard transaction.[3]

Not only is the 837 influenced by this confusion, but other transactions are impacted as well. Regardless of the definition of the claim or encounter, the 835 transaction is specifically detailed to exchange between a health plan and a health care provider:

> The health care payment and remittance advice transaction is the transmission of either of the following for health care:
> (a) the transmission of any of the following from a health plan to a health care provider's financial institution:
> a. Payment
> b. Information about the transfer of funds
> c. Payment processing information,
>
> (b) The transmission of either of the following from a health plan to a health care provider:
> a. Explanation of benefits
> b. Remittance advice
>
> See § 162.1601

The follow up to the question and answer detailed above from the preamble includes the following additional information:

> However, note that the health plan premium payment transaction from the State Medicaid agency to the health plan would have to be conducted as a standard transaction because the State Medicaid agency is a covered entity sending the transaction to another covered entity (the health plan), and the transaction meets the definition of health plan premium payment.[4]

In another example, the 276/277 Health care claim status transaction is defined as (a) an inquiry to determine the status of a health care claim, or (b) a response about the status of a health care claim. If the 837 is not a claim, but rather an encounter, then the 276/277 is not a beneficial transaction to another health plan.

[3] Preamble to the Standards for Electronic Transactions Final Rule, August 14, 2000. Section III, A, 6. Exception for Transmissions within Corporate Entities.
[4] Preamble to the Standards for Electronic Transactions Final Rule, August 14, 2000, Section III, A, 6. Exception for Transmissions within Corporate Entities.

3.3 HIPAA Implications

While this decision may appear to be a very basic or simplistic one, it is necessary to determine how SD/MC is *required* to comply with HIPAA. The goal of Administrative Simplification is to ease the burdens of administrative tasks between the health care provider who sees the patient and the agency or entity that pays for that care by making those tasks uniformly electronic.

3.3.1 Counties as Health Plans

Both DMH and ADP have determined that their preferred mechanism for service delivery is a partnership between the state department and the counties in California. DMH and ADP have initiated that partnership with contracts enabling the counties to determine the need for various types of providers and to enter into subcontracting processes, if necessary, to secure those services. DMH and ADP have further supported this partnership by providing funding to the counties in three separate ways that are removed from the direct claiming process:

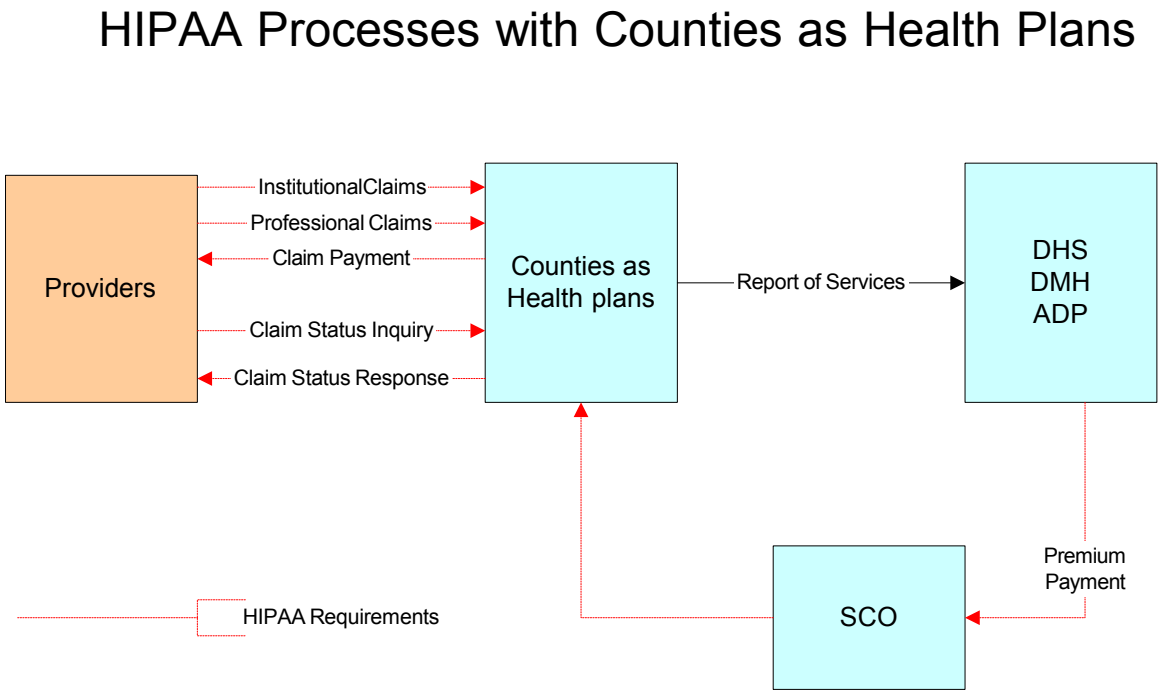
- Direct advance payments of State General Fund (SGF) up to 1/12 of the contract budget SGF per month
- Payment for administrative costs incurred for arranging or brokering health care services
- Annual settlement process based on the *cost* of providing services differentiated from the *charges* for those services.

Counties, likewise, have contributed to a Health Plan definition by paying providers for the services that have been rendered. In some cases, these payments have been advance payments as well.

3.3.2 Counties as Health Plans – HIPAA Implications

In an effort to simplify the administrative processes in health care, the TCS rule attempts to define the entities that participate in the health care system. Such definitions include providers, health plans, sponsors, subscribers, patients, etc. These definitions do not always fit government agencies perfectly, so some extrapolation must occur. HIPAA TCS defines a health plan as any entity "that provides or pays for the cost of health care." In their relationship with face-to-face providers, the counties meet this definition—at least partially. Since HIPAA seeks to simplify the relationship between the providers of care and the entities paying for that care, the TCS rules would seem to apply to the relationship between the counties and their subcontracting providers. HHS might apply the requirements of TCS to the counties so that the processes involved with paying providers for their care is simplified and expedited at the lowest possible level. While this might impose the burdens of HIPAA TCS to each county, it also affords that county the benefits of more direct control over the services provided by the entities with whom they have contracted. At a very high level, the

electronic exchanges of information, related to the four HIPAA transactions in this engagement, between the entities involved would be represented by the diagram below:



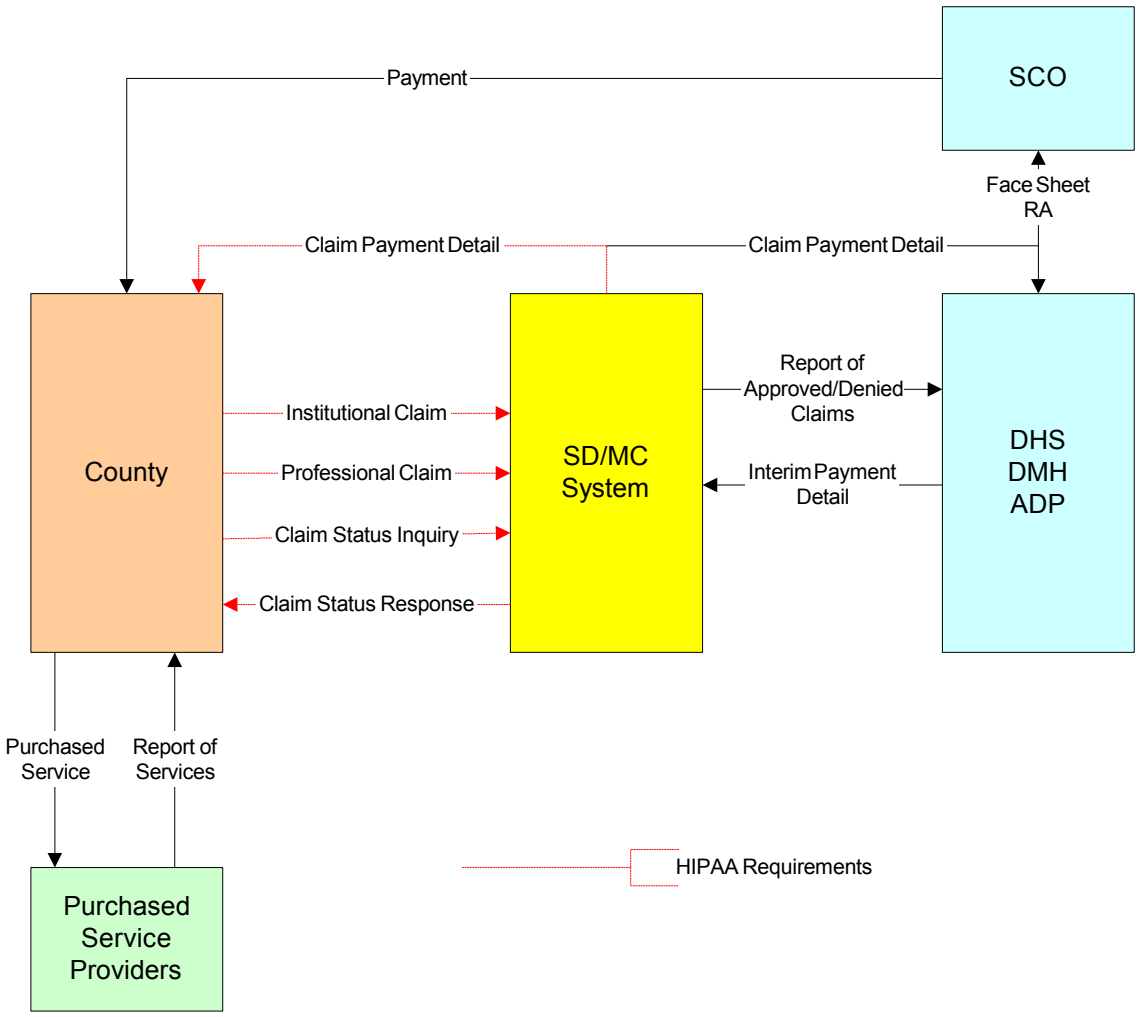
3.3.3 Counties as Providers

It is also possible that DMH and ADP could determine that their partnership with the counties is one based on the *provision* of health care. In this case, the counties' purpose is to assure that services are *provided* to Medicaid recipients. Where they are unable to supply the services themselves, they may choose to enhance or supplant their service by purchasing service from other providers for whom they serve as billing agents. This process would be similar to a situation where a large medical office had a roster of various types of providers, but served as the billing agent for all of them. In addition, such an office might subcontract for such services as laboratory or radiology services for which the office pays directly, but submits bills to insurance companies for those purchased services. These additional providers serve to extend the capabilities of the county as a provider of mental health or substance abuse services.

3.3.4 Counties as Providers – HIPAA Implications

The goal of HIPAA TCS is to simplify the relationship between the provider of health care services and the entity that pays for that health care by making those administrative tasks uniformly electronic. In this case, the goal would be for the county, as a provider, to interact directly with the payment system. Each claim would be a request for payment and would be submitted and processed without human intervention and returned with the appropriate payment. In this case, the claim process would be with the SD/MC system. The batching, totaling, invoicing, and other manual processes would be replaced with a mechanism where the provider sends any type of batches of claims into the system. The system sorts and processes the claims, based on adjudication criteria established by DMH and ADP, and automatically generates a payment notification to the county and a payment request for processing through the SCO. Any interim payments must also be made through the system so that they can be accounted for and subtracted automatically from subsequent payments. This payment structure removes some of the HIPAA burdens from the counties. It does, however, require the county to be more vigilant in the quality of claims it submits, as the claim will generate the cash flow necessary to continue the provision of services. By serving as billing agent for subcontracting providers, the county will be responsible to assure that the information it receives from subcontractors is sufficient to generate a compliant HIPAA claim. This type of claiming process implies that the SD/MC system is interacting directly with the providers and that DMH, ADP and DHS will receive adjudication information *after* the claim has been processed, rather than the direct handling of the claim that currently occurs. Related to the transactions named in this engagement, the process would resemble the diagram below:

HIPAA Processes with Counties as Providers



3.3.5 Covered Entity Combinations

It is possible that there will not be one single decision regarding the covered entity status of the county partners. In addition, ADP has contracts with Direct Providers and acts directly as the health plan for these providers. Because of this, the system would potentially be required to determine whether incoming transactions are claims for payment or reports of service encounters. Using a complex set of rules, the system would then need to proceed to generate an accurate remittance advice/payment

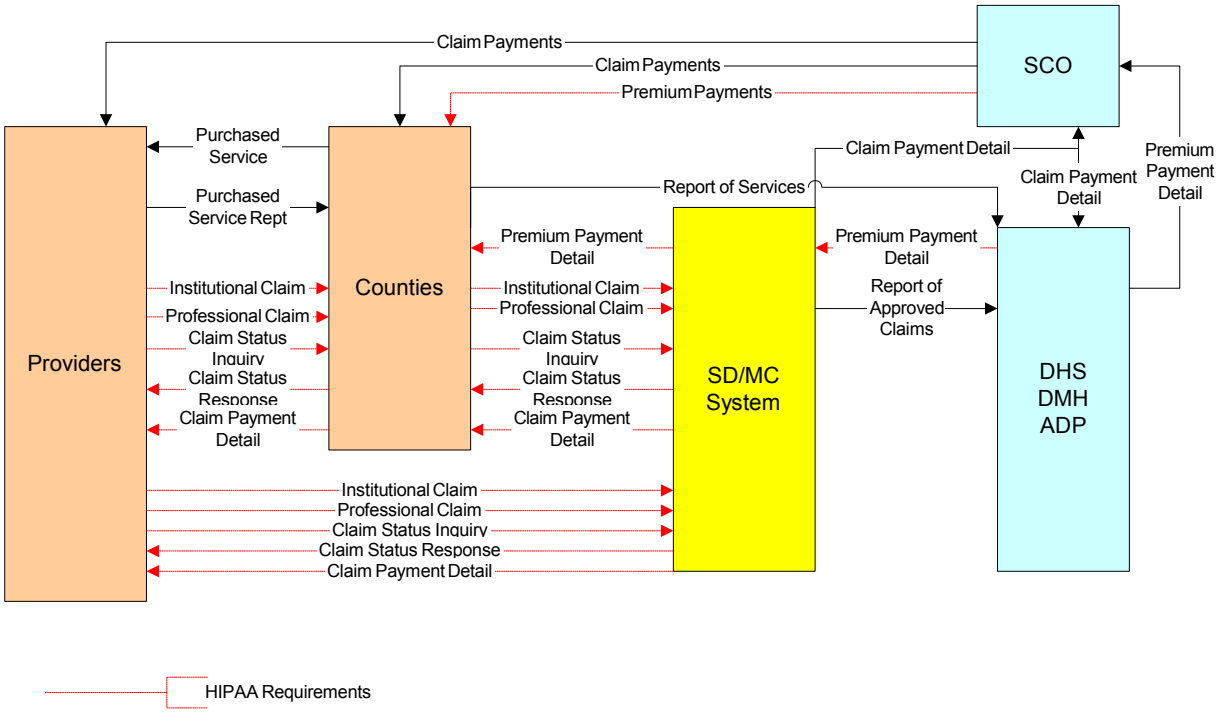
response for claims and some other payment structure for reports of services—generally an 820 premium payment. This report will attempt to address the business requirements of this type of system, allowing processes to support health plan and provider transactions. The ongoing goal is to have the system manage the complexities of incoming data, process correctly using pre-determined adjudication criteria, and return the appropriate outbound transactions with a minimum of manual intervention. The following table represents decision points and resultant transaction requirements.

Table 1. Covered Entity Decisions and Required Transactions

If the county is:	If the 837 is:	Required incoming transactions	Required outgoing transactions
A Provider	A Claim	837 I & P, 276	835, 277
A 'Billing/Pay-to' Provider	A Claim	837 I & P, 276	835, 277
A Provider	An Encounter	837	Any Payment Mechanism
A Health Plan	An Encounter	837	820
A Health Plan	A Report of Services	None	820

The complex system processing required for counties that serve as providers as well as health plans and including direct providers appears in the following diagram:

Complex System Processing for Counties and Direct Providers



Many state Medicaid agencies conduct business in ways that are unique in the health care world. Standard definitions do not always fit the delivery system utilized by state and county partnerships. Furthermore, the delivery of mental health services and alcohol and other drug treatment services may also not fit rigid molds established in physical medicine environments. It is most important, however, for governmental agencies to make determinations based upon their best assessment of the rules and definitions. From that point, it is critical to document the decisions reached and the reasoning behind such conclusions.

It is also important to note that any covered entities can choose to implement any transactions that meet their business purposes. Not only can health plans require that their providers submit electronic claims, but other entities can place requirements that are allowed by contract status, but that are not required by HIPAA. DHS can require that DMH and ADP submit information to them using 837 standard transactions. Likewise, DMH and ADP can place the same restrictions on their county partners. Furthermore, it is possible that these entities that are not required by HIPAA to conduct these transactions using X12 standards, may conduct their business using modifications to standard transactions without jeopardizing HIPAA compliance.

3.4 Business Requirements for HIPAA Compliance

There are a number of general business functions that are required for HIPAA compliance. These functions are both technical and business in nature and are not necessarily requested by any particular entity. They do not necessarily represent specific changes to inputs and outputs, but rather describe how the system must function in a HIPAA compliant manner. They may also reference the other HIPAA rules as they impact the TCS compliance. For example, under HIPAA Privacy, a health plan must be able to produce claim adjudication and payment records for any patient/client who might request them. Although Privacy is outside of the scope of this engagement, it becomes a HIPAA TCS requirement that the system—or some type of decision support system closely linked—produce such information for a period of 6 years as required by HIPAA (perhaps 7 years by California law). Another example references the system's ability to use look-up tables to properly adjudicate claims. These tables will change with irregular frequency, e.g. provider files and patient eligibility files may change daily, while procedure codes may change quarterly or annually. Unless the system is capable of referencing these types of tables, ongoing maintenance of the system will be extraordinarily difficult. Table 2. represents those general business functions that must be part of a HIPAA compliant system.

Table 2. General Business Functions Required for HIPAA Compliance

Unique ID	Gap	Requirement
F1	HIPAA transactions are only identifiable by manually labeling batches	The system must receive envelopes of transactions, which it must be able to identify, open, and sort the functional groups inside without human intervention.
F2	SD/MC cannot discern various types of transactions	The system must be able to receive and process the required HIPAA transactions, e.g. 837 I, 837P, and 276 as well as three versions of each transaction: the previous version (once a new version is named), the current version, and a future version in testing.
F3	SD/MC can only determine the payer by manually labeling batches	The system must determine which program is the responsible payer as well as unique characteristics of the payment method, e.g. DMH paying for EPSDT services differentiated from ADP paying for Drug Medi-Cal Services.

Unique ID	Gap	Requirement
F4	SD/MC can only process service line level type claims	The system must be able to process payment request at the claim and service line level. It must further be able to return payment and adjustment information based on transaction, claim and service level balancing
F5	SD/MC only recognizes the billing county or provider by means of manually labeling batches from that provider	The system must open the envelope and determine the entity sending the transaction and the entity to whom payments should be sent.
F6	SD/MC sends EOB transactions electronically which do not meet HIPAA compliance standards	The system must send a compliant 835 transaction that balances at the transaction, claim and service line level. Information regarding suspended claims must be sent in a separate transaction. Only HIPAA compliant adjustment messages can be sent electronically
F7	SD/MC does not recognize compliant codes that can be included in a transaction	The system must recognize compliant codes and allow them into the system. There is no requirement to use such codes in adjudication, but the system must not reject transactions that contain compliant codes.
F8	SD/MC uses field location to determine values	The system must recognize loop location and qualifiers to determine field values
F9	SD/MC uses field location to determine payment logic	The system must be able to manage hierarchical levels, looping structure, and the presence or absence of sub-loops to process adjudication
F10	SD/MC uses hard coded values in processing	The system must be able to manage multiple tables of information that will change regularly, such as procedure code lists that will change quarterly, and diagnosis codes that change at least annually. The system must also recognize origination dates and sunset dates of tabular information.
F11	Not all SD/MC dates are Y2K compliant (i.e., full year, month and day)	The system should handle all dates and date ranges in the typical HIPAA transaction format, CCYYMMDD.

Unique ID	Gap	Requirement
F12	Transactions rely on only one set of procedure codes	The system must be able to associate transaction versions and code set versions with dates of service and dates of submission. The transaction version must be compliant with the date of submission while the code set version must be compliant with the date of service
F13	Claim related information exists in various systems and many formats	Covered entities must produce claim adjudication and payment information to the patient if requested to do so. The information must be in a format that the client can understand. Information must be available in 5 days. All data from claims or adjudication must be available for this type of processing
F14	Claim related information exists in a variety of proprietary code structures and formats	The system should be able to produce information in a format necessary to report to federal agencies and state oversight agencies. If proprietary codes are used within the system, they should be translated back out for reporting purposes, for decision support purposes, and for internal research purposes.
F15	Claims must be submitted by the end of the month following the provision of service (ADP Only)	The system must be able to organize services by dates of service regardless of when the claim is received.
F16	There is no specific mechanism for the system to recognize and register payments made outside of the claim adjudication processThere is no specific mechanism to pay a set or premium rate	The system must be able to recognize when payments are made outside of the adjudication process and must generate an 820 to match the payment
F17	There is no mechanism to void a previously adjudicated claim	The system must be able to process voids, corrections, and resubmissions of claims and must be able to send reversals and corrections of 835 remittance transactions.
F18	Claim adjudication and payment information must be maintained for 6 years under HIPAA—perhaps 7 years for California law.	This data must be maintained somewhere for client access and also for HHS audits in the event of complaint. The system must also be able to produce a compliant 837 claim from its data collections.

Unique ID	Gap	Requirement
F19	Little documentation exists regarding how the system works, what changes have been made, and how users can secure modifications to the system	To keep up with HIPAA, accurate records will need to be kept regarding system modifications, and clear instructions on how to process through the system.
F20	The system is not flexible for change and does not store documentation for extended periods	The system must be flexible enough to make changes required by irregular releases of HIPAA rules and implementation guides. For HIPAA compliance purposes, SD/MC must be able to produce any HIPAA compliant transaction occurring over a period of 6 years, beginning October 16, 2003.

Throughout this engagement, the SAIC/HIPAA Team has looked at the discreet business functions of DMH, ADP and DHS to determine which processes meet HIPAA definitions and which ones must be changed. In some cases these lines are not distinct, so a current business function in conflict with HIPAA requirements may allude to a new business function required for HIPAA compliance. It is our desire to present these business functions in four categories:

- Business functions that are currently compatible with HIPAA requirements—although the mechanism for performing the function may not be compatible;
- Business functions that are in conflict with HIPAA requirements;
- Current business functions not covered by HIPAA; and
- New business functions required for HIPAA compliance.

It is important to keep in mind that the business functions of DMH and ADP have been constrained for some time by the functioning of the system. Manual processes have been the norm because automated ones were functionally difficult or impossible. HIPAA provides an opportunity and incentive to make changes that are not only required, but are advantageous as well. These business process changes, however, require organizational initiative, partnership communication and decision-making, and a desire to move to a more automated business structure. These cultural changes may present significant challenges that may exceed the requirements to re-engineer the system itself.

Table 3. Business Functions Compatible with HIPAA Requirements

Business Functions Compatible with HIPAA Requirements					
ID	**Description**	**Resp. Org.[5]**	**Man/ Opt[6]**	**Downstream Impacts?**	**Issues**
A1	Request for payment is received from direct providers and counties	DMH ADP	M	Y	A mechanism has been developed to receive and translate HIPAA compliant claims.
A2	Phone calls regarding status of claims	DMH ADP	M	Y	This business function relates to the named 276/277 transaction and therefore must be able to be conducted in the standard format
A3	Sending information related to the approval of claims for payment	DHS	M	Y	This business function is required. The current transaction is not HIPAA compliant without payment information and without balancing.
A4	When counties are overpaid, subsequent payments are withheld for recovery	DMH ADP	M	Y	This is allowable with the full use of the 835
A5	The appropriate Federal Financial Participation level must determined based on patient eligibility, the type of service, and the date of payment (or acceptable alternate).	DHS	M	N	This can be addressed with internal processing rules.

[5] This is an indicator of the organization that either specifically requested a requirement or that the requirement was developed through documentation or meetings with the organization listed.
[6] This is the determination of whether the requirement must be met to ensue HIPAA compliance. M = Mandatory and O = Optional.

Table 4. Business Functions in Conflict with HIPAA Requirements

Business Functions in Conflict with HIPAA Requirements						
ID	**Gap**	**Requirement**	**Req Org.[7]**	**HIPAA M or O[8]**	**Trans**	**Issues or Comments**
B1	The current EOB is sent electronically but does not meet the HIPAA 835 requirements. It carries non compliant information and it does not balance with payment information	EOB information must be carried in a standard transaction. Information about suspended claims may be carried in the current mechanism or another transaction, such as the unsolicited 277	DHS	M	835	Information that is additional to what can be carried in a 835 can be sent electronically, but must not meet the definition of the intended transaction. E.g., additional local claim adjustment reason codes cannot be sent electronically; only HIPAA compliant code sets can be sent.
B2	Requests for payment can be voided, corrected and resubmitted in a HIPAA compliant format, therefore, the current process is non-compliant if conducted electronically	The ECR process must be changed to exclude the proprietary mechanism to send corrected claims.	DHS	M	837P or 837I	The electronic notification of suspended claims can continue in a proprietary format.
B3	Race and Ethnicity Codes do not appear on any HIPAA transactions in scope of this assessment	These codes can be used internally, but cannot be returned on any outbound transaction	DHS SD/MC	O	834	MEDS can continue to carry this data from enrollment, however no compliant eligibility inquiry can carry the information.
B5	Current diagnosis codes are not part of acceptable code lists in HIPAA transactions	Only ICD-9 codes are acceptable for HIPAA	ADP DMH	M	837P or 837I	

[7] This is an indicator of the organization that either specifically requested a requirement or that the requirement was developed through documentation or meetings with the organization listed.
[8] This is the determination of whether the requirement must be met to ensue HIPAA compliance. M = Mandatory and O = Optional.

Business Functions in Conflict with HIPAA Requirements						
ID	**Gap**	**Requirement**	**Req Org.[7]**	**HIPAA M or O[8]**	**Trans**	**Issues or Comments**
B6	DMH does not receive information on other payers	Third party payer information is required on the 837 if another payer is known to exist.	DMH	M	837P or 837I	There is no way for DMH to know that it is the final payer if no information regarding other payers has been submitted.
B7	Rendering provider information is not captured except for ADP counselor's initials	Rendering provider information must be recognized from the 837 information	DMH	O	837P or 837I	
B8	A different set of codes is used for Federal reporting than used in SD/MC	The system must accept and process HIPAA compliant codes	DMH	M	837P or 837I	
B9	DMH produces a tracking report to tell counties the status of claims in process	The system must be able to track and locate a claim in process in order to respond to a 276/277 request for claim status.	DMH	M	276/ 277	If sent electronically, this process is non-compliant with HIPAA. It can continue if sent on paper, although it might be considered offering incentives for providers to not submit HIPAA compliant transactions.
B10	ADP procedure reporting requirements are non compliant	The system must accept and process only HIPAA compliant procedure codes, i.e. HCPCS, CPT, and ICD-9 procedure codes.	ADP	M	837I and 837P	ADP is not obligated to pay on all valid procedure codes, but the system must accept any valid code and may not reject a transaction because it contains a valid code that is not payable.

Business Functions in Conflict with HIPAA Requirements						
ID	**Gap**	**Requirement**	**Req Org.[7]**	**HIPAA M or O[8]**	**Trans**	**Issues or Comments**
B11	Many reports and information are shared with counties electronically, such as the MEDS file	This practice can continue only if counties are other health plans—in which the exchange of data is not controlled by HIPAA TCS. Internal use is not covered.	DMH ADP	O	Various	Such information exchanges may be governed by HIPAA privacy and security rules, out of scope for this engagement.

Table 5. Current Business Functions not Covered by HIPAA

Current Business Functions Not Covered by HIPAA					
ID	**Gap**	**Requirement**	**Req Org.[9]**	**Trans**	**Issues or Comments**
C1	There is no HIPAA mandated mechanism for notifying the provider of a suspended claim.	The current process can continue or can be modified into a different process if agreeable with trading partners.	DHS		In general, claims should not be suspended for issues that would ordinarily create a denial, i.e. duplicate claims or incomplete claims. Claims may be suspended while awaiting paper attachments, etc.
C2	Aid codes do not exist in HIPAA transactions.	The system may continue to use them internally or it can discern the Aid code from specific data fields available on the transaction.	DHS		Although they may be used internally for processing, they may not be returned on any electronic transaction
C3	Mode Codes do not exist on HIPAA transactions	The system can continue to use them or can discern the information from data fields available on the transaction.	DHS		Significant impacts to existing data or downstream data.
C4	Service function codes do not exist on HIPAA transactions	The system can continue to use them or can discern the information from data fields available on the transaction.	DHS SD/MC		Significant impacts to existing data or downstream data.
C5	Data from approved transactions is loaded into CalSTARS and a paper Remittance Advice is generated	Paper processes that do not replace electronic transactions can continue	DMH ADP DHS	835	HIPAA does not require a change to current SCO paper processes.

[9] This is an indicator of the organization that either specifically requested a requirement or that the requirement was developed through documentation or meetings with the organization listed.

Current Business Functions Not Covered by HIPAA					
ID	**Gap**	**Requirement**	**Req Org.[9]**	**Trans**	**Issues or Comments**
C6	Provider file is updated in numerous ways	A provider file is referenced to adjudicate a claim however HIPAA does not govern how that file is established or maintained.	DMH ADP DHS		Although not governed by HIPAA, there were numerous comments about how the current process for provider updates is problem prone.
C7	Cost settlement is conducted at year end	HIPAA governs the payment process but does not affect an eventual cost settlement process	DMH ADP		Cost settlement does affect budgets and is conducted several years later. It may result in as much as 10-40% difference in the cost/value of services approved in adjudication.
C8	Counties have department-specific timely filing requirements to submit claims after the end of a service; late claims without "good cause" are denied	HIPAA does not deal with timely filing. It does enable the payer to impose timely filing requirements.	DMH ADP	837I and 837P	Timely filing rules will need to be incorporated into claim edits.
C9	DMH and ADP make SGF payments to counties prior to the delivery of services	These payments can continue. They can be accounted for in the 835 transaction later	DMH ADP	835	Care must be taken that these payments do not resemble premium payments for which an 820 transaction is necessary.
C10	Payment requires signed invoices from providers, counties, and ADP/DMH	HIPAA does not interfere with this process although the 837 transaction does allow for some options	DMH ADP DHS		See business process improvement table for options
C11	Adjudication runs are four times per month	HIPAA does not require specific timing for adjudication although it does specify that the provider cannot be adversely affected by the timing of EDI processes	DHS		

Current Business Functions Not Covered by HIPAA					
ID	**Gap**	**Requirement**	**Req Org.[9]**	**Trans**	**Issues or Comments**
C12	Data reports are sent to the DHS Management Information System/ Decision Support System (MIS/DSS) and to federal agencies requiring such reports	MIS/DSS and federal reporting are outside of HIPAA TCS but are not expected to conflict	DHS		Federal reporting and MIS/DSS should use the HIPAA mandated data format, such as standard codes, etc.
C13	ADP and DMH receive data outputs that are used for decision support	These are not governed by HIPAA. Some data translation between old and new codes may be necessary to compare historical data to new data	DMH ADP		Decision support systems that contain the majority of claim and payment data are necessary when claims are adjudicated and paid automatically
C14	Use of 997 to acknowledge receipt of claims	The 997 is not required for HIPAA but serves to identify major syntax errors on submitted transactions.	DMH ADP DHS	997	

Table 6. New Business Functions Required for HIPAA Compliance

New Business Functions Required for HIPAA Compliance						
ID	**Gap**	**Requirement**	**Req Org.[10]**	**HIPAA M or O[11]**	**Trans**	**Issues or Comments**
D1	There is no way to determine the rendering provider	HIPAA requires that the system determine the provider that actually conducted the health care. .	DMH	O	837I and 837P	
D2	There is no way to determine the supervising provider	California service delivery may required that unlicensed providers be supervised by licensed providers and the system must recognize the supervising provider	DMH	O	837I and 837P	
D3	Both ADP and DMH bundle and unbundle claims, that is, they pay a global rate for services which might be itemized by providers	Bundling and unbundling must be accounted for in return transactions along with how payment was determined	DMH ADP	O	835	Line items are detailed in 835 return transactions
D4	The system does not have a way to track a claim through the adjudication process	A single claim must be identifiable for voids and corrections as well as for tracking in the 276/277	DMH ADP	O	837I 837P 835 276/ 277	The payer claim control number (ICN/DCN) is assigned to the claim, is used if the claim is resubmitted, is returned in the 835 and is located for information on the 276/277

[10] This is an indicator of the organization that either specifically requested a requirement or that the requirement was developed through documentation or meetings with the organization listed.
[11] This is the determination of whether the requirement must be met to ensue HIPAA compliance. M = Mandatory and O = Optional.

New Business Functions Required for HIPAA Compliance						
ID	**Gap**	**Requirement**	**Req Org.[10]**	**HIPAA M or O[11]**	**Trans**	**Issues or Comments**
D5	Current patient identifiers are not standardized	The system must determine what patient identifiers should be sent in the transactions and notify trading partners of those requirements in companion documents.	DHS SD/MC	M	837 I and 837P	Notes indicate that the CIN is the preferred client identifier, but the impact of any decision must be carefully studied. The system currently can use the CIN to find the SSN to determine eligibility.
D6	DDE applications between counties and ADP or DMH are not compliant	If counties are determined to be providers, then DDE applications must be compliant with data content of HIPAA transactions.	DMH ADP	M	837 I 837P 276/ 277	Some data sharing with counties meets the definitions of HIPAA transactions. Where counties are considered healthcare providers, these must be conducted with standard data content or standard transactions.
D7	SGF payments to counties may meet the definition of premium payments if the county is a health plan.	The system may be required to conduct an 820 premium payment transaction for these payments.	DMH	M	820	Many decisions about new processes and data transfers rest on the definition of the covered entity status of county trading partners.
D8	All claim status inquiries are conducted via manual telephone and email processes	SD/MC must have the ability to receive a 276 claim status inquiry and respond with claim information in the 277 format	DHS SD/MC	M	276/ 277	

New Business Functions Required for HIPAA Compliance						
ID	**Gap**	**Requirement**	**Req Org.[10]**	**HIPAA M or O[11]**	**Trans**	**Issues or Comments**
D9	HIPAA transactions provide many more dates than what are either received or used in MSD processing.	Maximize use of submitted dates to avoid unnecessary suspensions or denials.	DMH ADP	O	837I and 837 P	Processing dates as received on claims will expedite some processing and reporting issues.
D11	The system does not process more than one diagnosis	HIPAA enables the use of 8 diagnoses for the professional claim and 12 for the institutional claim. The system must receive compliant information that is contained in the claim	DMH ADP	M	837 I and 837 P	Numerous entities requested the ability to manage more than one diagnosis. Particularly important for ADP when specific services are for pregnant women or when treating patients with multiple diagnoses along with substance abuse.
D12	Some claims are forced due to use of the override codes, which may be placed somewhat arbitrarily.	HIPAA does allow for the inclusion of some override indicators. The system must determine if those indicators are sufficient, in conjunction with other claim data, to force payment of the claim	ADP DMH	O	837 I and 837 P	The system should use edit criteria to determine override status, not allow the presence of the code to force the claim.
D14	MSD does not use total amount billed as part of the processing to determine the amount paid.	Total amount billed is required data field of the 837 claims; total amount paid on 835 must balance at three levels (transaction, claim, and service).	DMH	M	837 I and 837 P	

New Business Functions Required for HIPAA Compliance						
ID	**Gap**	**Requirement**	**Req Org.[10]**	**HIPAA M or O[11]**	**Trans**	**Issues or Comments**
D16	Beyond overall eligibility status, SD/MC has no editing related to Share of Cost (SOC).	SOC can be transmitted on 271 transactions. Collected patient fees must be reported on the 837 and can be used in adjudication as appropriate	ADP DMH DHS	M	271 837I 837P 835	SD/MC can process claims where SOC was met but an amount was still due to the provider. This way the claim pays but with reduced amounts. Subsequent claims pay in full.
D17	Counties would like to utilize Secure FTP to receive and transmit HIPAA transactions.	HIPAA security regulations will require a secure transfer mechanism. Secure FTP is only one way to achieve this.	County	O	Various	HIPAA requires secure transfer.
D18	Coordination of Benefits (COB) is not supported by SD/MC	COB from provider to payer is required in HIPAA, COB from payer to payer, EDI, is not required but is available with trading partner agreement.	County	M	837 I and 837 P	
D19	No way to determine if additional documents are attached to the claim	System must be able to recognize the presence of attachments	DMH ADP	O	837 I and 837P	Certification forms are attached to claims
D20	No way to determine the qualifiers for other data elements, such as units, identifiers, etc.	The system must recognize and appropriately process qualifiers	DHS SD/MC	M	837I 837P 276	Qualifiers enable the system to sort out data that follows to enable appropriate processing

4. Gap Regulations

4.1 Introduction

The Regulatory Review subsection of the business requirements continues the analytical process of identifying California SD/MC laws impacted by HIPAA. In the previous deliverable, an overview of HIPAA Transactions and Code Sets regulations and California laws potentially impacted by HIPAA were set forth. Laws identified as having a likely HIPAA impact are analyzed in this business requirements section for quantity and type of impact; potential changes needed; and risks associated with not changing California laws. The rule making authority of DHS, ADP, DMH, and MRMIB is also presented along with a section identifying existing procedures necessary to change CA law.

4.1.1 CA Law Conflicts

This section identifies State laws and regulations in conflict with HIPAA requirements and identifies potential changes to CA laws or potential new CA laws needed to comply with HIPAA requirements. The analysis is presented in table format. Table headers and columns are explained below, followed by tables for each agency.

Column Heading:	Current Regulation
Column Description:	Section/Title/Specific Description of CA law
Column Heading:	HIPAA Requirement
Column Description:	Identification of HIPAA requirement implicated and description of action needed for compliance.
Column Heading:	Impact
Column Description:	Choice of three impacts: None, Indirect, Direct. Describes type of impact HIPAA has on the CA law.
Column Heading:	Action
Column Description:	Choice of four actions necessary to align state law with HIPAA 1. No law change needed. May require policy/procedure modification to change any conflicting implementation approach currently in effect. 2. Re-wording may be required to specific provision(s) 3. Major Sub-section/Section change may be required 4. New law required

Column Heading: Risks

Column Description: Choice of three types of risks incurred if action to align state law with HIPAA is not taken.

1. N/A –no risks related to compliance with HIPAA TCS requirements are present because there is no conflict with current law.
2. Requiring business partners to conduct business using currently invalid state law (or provision of state law) for conducting transactions covered by HIPAA TCS presents risk of complaints to HHS and potential enforcement action against DHS. Enforcement action could include a requirement to implement an HHS approved compliance plan (which may or may not include approaches selected by DHS), fines, and for Medicaid programs, potential reduced federal financial participation.
3. Leaving currently invalid state law (or provision of state law) in place, but requiring business partners to follow HIPAA requirements presents no HIPAA compliance risk, but does present practical risks. DHS may find it politically and practically difficult to act inconsistent with state statutes and regulations requiring specific action even though state laws conflicting with HIPAA requirements were automatically preempted with respect to transactions governed by HIPAA TCS. There is a risk that inconsistent information will be provided regarding which law governs in a particular situation both because staff may be confused and because only those provisions, or parts of provisions, in conflict with HIPAA are preempted, not necessarily an entire law or code section. Greater submission errors could occur due to business partner confusion related to which law to follow in order to have their transaction processed by DHS.

Table 7. DHS – Medi-Cal Laws

Current Regulation		HIPAA Requirement	Impact			Action				Risks		
			None	Indirect	Direct	A1	A2	A3	A4	R1	R2	R3
W & I §14021.6	Medi-Cal drug treatment program –maximum allowable service rates *(Subsection b-already compliant)*	*N/A* - Service *codes described reference HIPAA required codes*.	✓			✓				✓		
W & I §14021.6	Medi-Cal drug treatment program –maximum allowable service rates *(Subsections c,d,e)*	45 CFR 162.1002 Medical Data Code Sets *Change service descriptions to be consistent with required codes*.			✓		✓				✓	✓
T. 22 §51490	Claim Submission Requirements for Counties and Providers for Short—Doyle Medi—Cal Providers *(Subsection a)*	45 CFR 162.923/925 Requirements for Covered Entities and Health Plans *Ensure required system (Short-Doyle system) is also HIPAA compliant.*		✓		✓				✓		
T. 22 §51490.1	Claim Submission Requirements for Counties and Providers of Drug Medi-Cal Substance Abuse Services. *(Subsection c,d)*	45 CFR 162.923/1000 Requirements for Covered Entities and Code Sets *Change name of transaction and codes to be consistent with HIPAA (e.g. Error Correction Report and Override Code)*.			✓		✓				✓	✓
T. 22 §51502	Billing Requirements	45 CFR 162.1101 Health Care Claim *Change billing Requirements to be consistent with HIPAA*.			✓			✓			✓	✓
T. 22 §51516	Reimbursement for Short-Doyle/Medi-Cal Services	N/A	✓			✓				✓		
T. 22 §51516.1	Reimbursement Rates for Drug Medi-Cal Substance Abuse Program Services	45 CFR 162.1002 Medical Data Code Sets *Change service descriptions (in Rates) to be consistent with required codes.*			✓		✓				✓	✓

Table 8. DMH – Specialty Mental Health Waiver Laws

Current Regulation		HIPAA Requirement	Impact			Action				Risks		
			None	Indirect	Direct	A1	A2	A3	A4	R1	R2	R3
W & I §5610	County mental health system reporting requirements (*Subsection a,b)*	45 CFR 162.923/925 Requirements for Covered Entities and Health Plans *Ensure implementation of data collection requirement is consistent with HIPAA data elements for covered transactions.*		✓		✓				✓		
W & I §5650	County Mental health services performance contract	N/A	✓			✓				✓		
W & I §5651	County Mental health services performance contract assurances (*Subsection a)*	45 CFR 162.923/925 Requirements for Covered Entities and Health Plans *Ensure implementation of requirements to submit data in specified format is consistent with HIPAA for covered transactions.*		✓		✓				✓		
W & I §5705	Negotiated net amounts or rates *(Subsection b(2))*	45 CFR 162.923/925 Requirements for Covered Entities and Health Plans *Ensure implementation of requirements to submit data/service information is consistent for HIPAA for covered transactions.*		✓		✓				✓		
W & I §5707	Fund administration and allocation	N/A – *Indicates that if conflict, Federal requirements, which would include HIPAA, related to funds allocation are controlling*.	✓			✓				✓		
T.9 §1715	MHP Payment Authorization (definition)	45 CFR 162.1301 Referral Certification and authorization transaction. *Ensure implementation of payment authorization is consistent; consider name consistent with HIPAA definition.*		✓		✓				✓		

Current Regulation		HIPAA Requirement	Impact			Action				Risks		
			None	Indirect	Direct	A1	A2	A3	A4	R1	R2	R3
T.9 §1717	Point of Authorization (definition)	45 CFR 162.925 Requirements for health plans *Ensure point of authorization is consistent with HIPAA requirement to provide capability using standard electronic transaction.*		✓		✓				✓		
T.9 §1720	Receipt or Date of Receipt	N/A	✓			✓				✓		
T.9 §1722	Short-Doyle/Medi-Cal provider (definition)	N/A – *provider is also HIPAA covered entity if submitting transactions electronically*.	✓			✓				✓		
T.9 §1723	Submit or Date of Submission (definition)	N/A – *but if receive electronically, may need to add an electronic date/time indicator to definition.*	✓			✓				✓		
T.9 §1725	Applicability of Laws and Regulations	N/A – *requires compliance with both federal and state provisions*.	✓			✓				✓		
T.9 §1727	Implementation Plan for Psychiatric Inpatient Hospital Services.	N/A – *if covered, MHP procedure for prior authorization needs to be HIPAA compliant*	✓			✓				✓		
T.9 §1739	Allowable Psychiatric Accommodation Code	45 CFR 162.1002 Medical Data Code Sets *Ensure codes are consistent with required codes for covered entities*.			✓		✓				✓	✓
T.9 §1772	Prior Authorization	45 CFR 162.925 & .1301 Requirements for health plans & Referral Certification and authorization transaction. *Ensure "written" includes electronic process.*			✓		✓				✓	✓

Current Regulation		HIPAA Requirement	Impact			Action				Risks		
			None	Indirect	Direct	A1	A2	A3	A4	R1	R2	R3
T.9 §1777	MHP Payment Authorization by a Point of Authorization.	45 CFR 162.925 & .1301 Requirements for health plans & Referral Certification and authorization transaction. *Ensure "written request" includes electronic process.*			✓		✓				✓	✓
T.9 §1820.100	Definitions "Allowable Psychiatric Accommodation Code"	45 CFR 162.1002 Medical Data Code Sets *Ensure codes and descriptions are consistent with required codes for covered entities*.			✓		✓				✓	✓
T. 9 §1840.110	Claims submission	45 CFR 162.923/925 Requirements for Covered Entities and Health Plans *Ensure required system (Short-Doyle system) is also HIPAA compliant.*		✓		✓				✓		
T. 9 §1840.112	MHP claims certification and program integrity	45 CFR 162.1101 Health Care Claims or Equivalent Encounter. *If claims certification is part of standard transaction, ensure data required to be collected is consistent with HIPAA.*		✓		✓				✓		
T. 9 §1840.304	Crosswalk between service functions and HCPCS codes	45 CFR 162.1002 Medical Data Code Sets *Ensure codes and descriptions are consistent with required codes for covered entities*.			✓		✓				✓	✓

Table 9. ADP – Drug Medi-Cal Laws

Current Regulation		HIPAA Requirement	Impact			Action				Risks		
			None	Indirect	Direct	A1	A2	A3	A4	R1	R2	R3
N/A	No laws or regulations with likely HIPAA impact	None	✓			✓				✓		

Table 10. MRMIB – Health Families SED Laws

Current Regulation		HIPAA Requirement	Impact			Action				Risks		
			None	Indirect	Direct	A1	A2	A3	A4	R1	R2	R3
N/A	No laws or regulations with likely HIPAA impact	*None*	✓			✓				✓		

4.1.2 Short-Doyle Medi-Cal Rule-Making Authority

The following table displays California Code citations that grant an agency rule-making authority over general activities as well as specific authority over Short-Doyle Medi-Cal program issues. In general, it should be noted that when read as a whole, it is clear that the legislature recognized that multiple agencies have jurisdiction over services provided under SD/MC, but that integrating services to provide better care to individuals and maximizing federal and other funding sources dictated a more comprehensive program that the agencies work collaboratively on:

- DHS as the single state agency administering Medi-Cal
- DMH as the state agency responsible for mental health services
- ADP as the state agency responsible for alcohol and drug addiction services
- MRMIB as the state agency administering Healthy Families, including a benefit for children with Severe Emotional Disturbances

Due to the fact this is not a "new" program, but rather one that has grown out of various mandates with pre-existing parts of the program in place, the lines of authority for the overall program, or specific components are less than clear. However, each agency has general authority to conduct business within its mandate, and SD/MC involves services and funding within the mandate of all the agencies. Thus, each agency could act under its general authority in promulgating or changing regulations for components of the program that fall within its jurisdiction. Additionally, specific authorities for certain aspects of the program are set forth below.

Table 11. Rule Making Authority

Area of Authority	DHS	DMH	ADP	MRMIB
General Department Authority	W&I 10725 W&I 10750	W&I 4005.1 W&I 4011	H&S §11755	I §12693.20 I §12693.21
SD/MC programmatic authority	W&I 14021	W&I 5750 W&I 5600.3 W&I 4024.5	H&S §11758.40 H&S §11758.41 W&I 4024.5	I §12693.61
SD/MC Definition of Services authority	W&I 14021 W&I 14021.35		H&S §11758.46	
SD/MC Rates of Reimbursement authority	W&I 14021.35 W&I 14021.5(c) W&I 5724	W&I 5724	H&S §11758.42	

SD/MC Systems and data reporting authority		W&I 5610 W&I 5650 W&I 5705	H&S §11758.46(d)	

4.1.3 Process for changing CA Law

This section identifies DHS' procedures to change California law. If a change is required to California Code (statute such as the Welfare and Institutions Code), then it must be proposed to the legislature for action. If a change is required to California Code of Regulations (regulations such as title 9), then the state agency has the authority to make the change. The DHS identified procedures for these changes are set forth below.

Procedures necessary for DHS to request a change to California Code

Overview
As noted above, changes to the California Code require the action and approval of the California legislature. State agencies can prepare proposals for legislative action. Legislative proposals at DHS are coordinated through DHS' Legislative and Governmental Affairs Office. The main office phone number is 916-657-2843 or 916-654-0584 for general information and to be directed to the appropriate legislative coordinator. Forms can be viewed at http://intranet.dhs.ca.gov/publications/forms/formsindex.htm

Authority
The legislative office, coordinating with the Director, Chief Deputy, and Deputy Directors determine the need for new or modified legislation.

Procedure
DHS' process is a two-phased approach: first a legislative concept is developed, and if the concept is approved, a legislative proposal is developed. Note: a yearly legislative schedule is released to division chiefs and above in late July/early August that outlines the Agency and Governor's Office deadlines.

The first step is to develop a legislative concept. A deputy director must originate the Request for Approval of Legislative Concept (form available). This is a one-page document submitted to the legislative office identifying the problem, proposed solution, and impact. The initiating program must get appropriate sign-off from division/section chiefs, chief counsel, budget/fiscal forecasting chief, and the program's deputy director. Once required sign-offs are in place, the legislative office will review and then coordinate the approval process.

If the concept is approved, then deputy directors (and their program) must develop a full legislative proposal. Proposals are developed on a Request for Approval of Proposed

Legislation (from available) and address the same subject areas as the concept. However, each area needs to be fully explained, and thus additional detail and more pages to adequately explain the proposal may be necessary. The initiating program works closely with legislative coordinators, and must get appropriate sign-offs, and a complete fiscal analysis. Approved proposals are forwarded in duplicate to the legislative office, who then forwards the proposal to the Health and Human Services Agency for review and approval. DHS' legislative office coordinates approval of the Health and Human Services Agency and the Governor's Office review and approval.

Procedures necessary for DHS to change its California Code of Regulations

Overview
Changes to the California Code of Regulation are agency generated and approved, after following requirements of the Administrative Procedures Act. Final approval and publication is handled through the Office of Administrative Law (OAL - another state agency) and Secretary of State. An initial package for the draft regulations are transmitted by a deputy director to DHS' Office of Regulations, which coordinates DHS' regulatory adoption, amendment, and repeal. The main office phone number is 916-654-0381 or www.dhs.ca.gov/regulation for general information or to be directed to the appropriate coordinator for specific programs.

Authority
The program originating the request, coordinating with DHS' Office of Regulations, and with approval of the program's Deputy Director determines the need for new or modified regulations.

Procedure
Program staff draft a regulation proposal package for their Deputy Director to approve and transmit to DHS' Office of Regulations (OOR). The program should decide whether the regulation is an emergency or non-emergency regulation. Generally, both types of regulations require the same documentation, but timelines for emergency regulation process and effective date are shortened. A detailed outline of the steps needed, and listing the legal authority and program objective(s) to be achieved is recommended as a first step. DHS' Office of Regulations has detailed instructional materials, checklists, and appendices with forms.

Preparation of the regulation proposal package is a major first step that requires substantial staff time in gathering and preparing information for the proposed regulation. Regulation packages must include: a transmittal memo signed by the deputy director; an Informative digest/Policy Statement Overview; Initial Statement of Reasons; Statement of Determinations; Economic Impact Statement; Statement required effect on small business; Fiscal Impact Estimate; Regulation Text; Advisory Group/Agency

comments/consultation/etc; CCLHO if required; List of Small Businesses to be noticed, if any; Mailing labels for persons or programs want to ensure receive a copy of the Notice; and for emergency regulations, a description of emergency facts.

The package is sent to the OOR for preliminary review; and then OOR coordinates subsequent review; approval; and comments. Reviews include legal, HHS agency, and budget reviews. A public notice package is drafted for legal/director review and, when approved, published and package mailed. Public comment period and a public hearing are held. Any necessary regulation text revisions are made by the program with approval from OOR, legal, and the director, and made available for public comment. A final package, with a Filing Order is prepared, approved by Director, and filed with OAL (the external agency). OAL reviews. If issues, OOR coordinates resolution. When OAL approves, it is filed with Secretary of State; and an effective date of filing is set.

5. Business Environment Changes

5.1 Claim Payment

The overall objective of this engagement is to "ensure that counties and providers can continue to be paid successfully for services rendered on behalf of the Short-Doyle program while implementing a HIPAA compliant system."[12] Throughout numerous interviews with diverse staff, a resounding comment was that payment does not currently track the claim submission process. It is difficult to strengthen the partnership between state departments and county entities for services rendered to Short Doyle clients when funding is not always forthcoming. The goal of HIPAA is to simplify the administrative burdens of health care by making this claiming process uniformly electronic.

For those counties who will be acting as health plans, the suggested mechanism for payment is the 820 premium payment. The assumption of this payment mechanism is that payment is regular, predictable and automated. It is difficult for a county health plan to budget for ongoing health care activities and sub-contracts with no idea how much money will be available for that effort. The HIPAA TCS Rule, however, does not specify that the payment must always be the same. It is possible that this type of payment could be variable, based on some reference to services rendered, however it is expected that the payment will be regularly extended to the county health plan in an automated fashion.

For those counties and direct providers who function as covered entity providers, the payment must be automated in direct response to claims submitted. In a perfect electronic world, a claim would be prepared by a human being and submitted, but from that point the adjudication, payment, and posting to the provider system would be entirely automated.

For many, this movement to more electronic and less manual business functions could be difficult. It means that people lose what they perceive to be control of the process. Counties would not need to batch claims by program and count them for program payment strategies. ADP and DMH would not handle claims before they are processed. They would not add claims for one program or another or need to determine the level of FFP that is expected. They would not check for a county total and make sure that matches their total. DHS would not re-add claim totals to assure that the totals are correct. All of these processes would be handled by automated system process to the extent they are still necessary. When these manual processes are automated, programs will have to develop other mechanisms to monitor the health care delivery process. It is

[12] Short-Doyle Medi-Cal HIPAA Phase II Scope and Goals, Version 1.3, Office of HIPAA Compliance, p 1

possible that the health care delivery mechanism will need to be redesigned. It is also possible that new or different levels of communication and trust will need to be initiated or strengthened.

What will be required of the new system is that it must work more efficiently and more accurately. Beginning with providers, the information submitted to the system must meet high standards of accuracy. The more accurate the claim, the more likely it can be processed correctly and paid immediately. To create this faster turnaround, the system must be built with good adjudication criteria. In order to determine the appropriate program, the system may need to read data from a number of different fields. For example, to recognize the payment mechanism for Healthy Families SED, the system may either read that from the name field of the payer, use an identifying payer number that engages payment criteria for this program, or gather eligibility data from another system. Perinatal programs for ADP will have to determine the existence of pregnancy by use of the pregnancy indicator, a pregnancy diagnosis, or a procedure modifier indicating pregnancy related services. Adjudication criteria will also need to include payment criteria that links to the proper identification of the client, the provider, the payer (ADP, DMH, Healthy Families), and the service rendered. FFP would still need to be determined based on the eligibility of the client, the type of service, and the date of payment (or accepted alternate) to meet federal requirements. Determination of appropriate adjudication criteria should be a process that is thoughtful, interactive, and collaborative. It also must be continually flexible, as programs, recipients and funding sources will surely change over time.

Equally as important as the adjudication system is the payment system. A HIPAA compliant remittance advice must carry the payment information (check number or EFT). Therefore a new interface with the SCO will be necessary to obtain that payment information to affix to the remittance advice. This may require that business processes change in order to draw down the FFP in a more timely manner. It may also require that appropriate adjudication automatically generates a request for payment from the SCO to the health plan or provider. Counties have requested electronic funds transfer (EFT), which is a standard payment mechanism that is not exceedingly complex, but enables them to have funding much more efficiently.

When adjudication and payment processes become more automated, the program administrators at DMH, ADP, and DHS will need other mechanisms to maintain control of program elements, service delivery, and available funding. This will require decision support systems that can query the data available from claim submission through payment to assure what types of services were delivered, who delivered them, what clients were served, how much was claimed, how much was paid, and when payment occurred. Policies and procedures, contracts and perhaps even laws may need to change to reflect the newer service delivery system. Programs have requested that the new system request MMIS certification so that IT processes can receive better funding.

Better IT processes will improve the tracking of service delivery and the reporting of services rendered to agencies that conduct oversight activities at a state and federal level.

5.2 Detection of Claiming Patterns Indicative of Potential Fraud

A number of interviews indicated that some program staff are concerned about claiming patterns that may indicate potential fraudulent activity. Some of the methods mentioned included duplicate claims, patient names that keep appearing on multiple claims, providers exceeding the possible number of hours available to work in a day, and providers with several provider numbers who make referrals to themselves. Where counties serve as health plans and must adjudicate claims themselves, these patterns must be detected at the county level before claims or reports are submitted to the SD/MC system. For those counties who act as providers and for direct providers, the system must be able to incorporate enough adjudication criteria to establish checks and balances for claiming patterns. Greater detail in the procedure codes accepted, the use of modifiers with procedure codes, more than one diagnosis code, the ability to check between programs (such as the various program payment sources at ADP), or periodically auditing rendering providers might influence this type of claiming pattern. Intensive adjudication criteria, along with user-friendly query capabilities on decision support systems are necessary to enable early detection of fraudulent activity or to establish that legitimate services have been provided and deserve adequate reimbursement. Additionally, increased data sharing between ADP, DHS, and DMH using standardized claim data can increase the ability to detect fraudulent activity within Medi-Cal as a whole.

5.3 Coordination of Benefits (COB)

Medicaid is generally the payer of last resort. This means that before payment is made on any claim, the system must determine that other payers have made their payments. A compliant HIPAA claim contains the information regarding this type of payment. The system must be set up to recognize that a third party has paid something towards the claim and must subtract that payment from what is owed to the provider. Appropriate adjudication criteria may be set up that looks for third party payments for types of claims where other payers are known to pay and bypasses that requirement for types of claims where no other payer covers the service. The system will also need to continue checking eligibility files to determine the presence of third party liability and deny claims until that information is submitted on the claim.

Coordination of Benefits conducted electronically between payers is not required by HIPAA but can be conducted with trading partner agreement. Most frequently this would occur with Medicare, but could occur with other payers as well. This capability

has been requested by program interview and should be incorporated into any system design moving forward.

The COB process requires absolute accuracy in both the claiming process and the adjudication criteria. While Medicaid rules demand that departments make every attempt to extract payment from other payers first, the improper application of these rules could jeopardize the cash flow for providers of care. SD/MC must expect accurate reflection of COB payments in claims that it receives, but it must also assure that the system correctly recognizes these amounts and pays appropriately.

5.4 Share of Cost

Medicaid has rules regarding how the appropriate share of cost (SOC) should be collected from the patient. It is sometimes difficult to coordinate how SOC is generated when the client may be served by a variety of providers who may be billing through more than one system. Additionally the adjudication criteria should establish that once SOC requirements have been met that adjudication should proceed. SD/MC must expect accurate reflection of SOC payments in claims that it receives, but it must also assure that the system correctly recognizes these amounts and pays appropriately.

6. Information Exchange Changes

Information exchanges will change to follow changes to business processes. It is necessary for the business partners involved in the SD/MC system to carefully examine the definitions of the required transactions along with the definitions of the entities conducting the transaction to determine requirements for HIPAA compliance. HIPAA TCS requires that "if a covered entity conducts, using electronic media, a transaction adopted under this part with another covered entity (or within the same covered entity), it must conduct the transaction as a standard transaction."[13] It also must not provide any incentives for any partner to not conduct the transaction using the standard. If DMH and ADP conduct electronic information exchanges with county partners that meet the definitions of standard transactions, then those information exchanges must be in the standard. This principle is best illustrated with an example:

> The SD/MC system accepts claims from county partners as providers. In an effort to improve the quality of the claims submitted, the SD/MC system returns an error correction report (ECR) to the county so that incorrect claims can be corrected for proper adjudication. Once errors have been corrected, the county sends a correction form on paper, which corrects the suspended record and

[13] Preamble to the Standards for Electronic Transactions Final Rule, August 14, 2000.

looks like a new claim. (There may soon be an option to submit corrections electronically). Error code messages indicate that many of the original errors involved data that was either missing or was invalid. Several of the errors appear to duplicate each other.

Examination of this process according to HIPAA definitions involves a complex process: 1) The parties conducting the transaction meet the definition of those who are required to conduct health care claims (county as provider and DMH/ADP as health plan); 2) There is no HIPAA named process to notify providers of suspended claims; 3) There is a HIPAA named process to submit a corrected claim; 4) There is a HIPAA named process to notify a provider that a claim is denied for specific adjudication criteria; 5) Missing data constitutes a claim that should not enter the adjudication system because the claim does not meet the criteria for a standard transaction; 6) Some error messages indicate that the claim was a duplicate claim or that the provider or the recipient did not match with information contained in files; 7) Denial codes from the Claim Adjustment Reason Code List closely approximate the error field indicator codes on the ECR.

Further analysis of these factors imply that it is possible that the ECR process is a process that may provide an incentive for trading partners to not conduct the standard transactions. It would seem that non-standard transactions can enter the adjudication system with missing data. It also appears that the criteria for error indication involves business processes that generally would deny the claim, e.g. client ineligible or duplicate claim. There is no named process to indicate a transaction that is suspended for correction, but there is a process to indicate that a transaction has been denied for various reasons. There is also a HIPAA compliant process to resubmit a corrected claim.

Analysis of the business processes indicates that the ECR process may also nullify many of the advantages to be gained from HIPAA compliance. The ECR process involves as many as 30% of the total claims received in some batches. Re-submittal of these claims as corrections involves extensive manual processes that do not seem to have a long-term corrective effect on the original claim submission process. Finally, the very adjudication criteria that is meant to distinguish claims and claiming patterns that *should* fail the adjudication process and alert the programs to possible fraud situations becomes moot when claims are simply changed to meet adjudication criteria.

This analysis makes three conclusions: 1) ADP and DMH should discontinue using the ECR process to correct claims and use the 837 void and resubmission process instead; 2) to the extent possible, claims currently suspended should be

denied and placed on the 835; 3) there is no specific requirement for communicating information about claims that must still be suspended.

Of course, the partners using the SD/MC system could arrive at entirely different conclusions with their analysis. They could determine that the county is a health plan and therefore the transaction is not governed by HIPAA. In that case, ADP and DMH would need to determine whether to require use of the HIPAA transaction standards as part of doing business, or to support existing or alternate methods of information exchange. Such decisions should be documented in the event that any complaints are received which must be defended against HHS investigation.

This type of analysis must be conducted for existing and newly requested information exchanges between trading partners. Tracking mechanisms for claim status may circumvent the Claim Status Request and Response transactions. Access to files, such as the MEDS file may circumvent the Eligibility Inquiry and Response transactions and the regular sharing of reports regarding claim adjudication approvals and denials may circumvent the Claim Payment and Remittance Advice transactions. Further analysis may also be necessary to comply with HIPAA Privacy and Security requirements.

6.1 Request for Payment

Another significant factor involved with the changes to information exchanges involves the total reliance on data contained in the standard transactions. If data can be submitted on a claim, it should not be requested at another time in another format. Initially, the system must recognize the different types of transactions from data contained within those transactions. The system also cannot depend on manual batching and department level edits to determine how to adjudicate a particular claim. Data from new code sets may not match data currently within the system. If the system is not changed to receive the new data, then it may need to be extracted from incoming data to process through the old system. For example, mode of service is not a HIPAA field. It may not be difficult to extract it from the type of claim or the place of service, but the system must be programmed to manage these new code structures. For a period of many years, it will also be difficult to compare historical data with new data due to the new code set requirements.

Once data has entered the system, the system must find ways to use it. New data is available to influence adjudication and new business processes. Not only should available data be used, but it often must be returned on HIPAA required transactions, such as the 835 Remittance Advice or the 277 Claim Status Response. While it is acceptable to strip off data that is not required for adjudication and restore it to outbound transactions, it is not recommended to request that data in another format for other informational purposes. Other significant changes will be required in the SD/MC

system to attain HIPAA compliance. Incoming data can appear at either the claim level or the service line level of the request for payment and must be sorted within the system to process accordingly. Additionally, the system must be able to manage claims that are voided, corrected or resubmitted for some other reason. Other data, such as important dates, prior authorization numbers from county processes, coordination of benefits information, rendering provider detail, and multiple diagnosis and procedure codes will be data content that can be invaluable to the business needs of ADP and DMH. Nonetheless, these changes to information received and used within the system will require significant changes to the system itself.

Consideration must also be given to the use of Direct Data Entry (DDE) mechanisms to receive claim information into the SD/MC system. Although ADP has had mixed success with this form of data submission, it is a possibility that must be considered while significant changes to a system are evaluated. DDE enables the health plan to provide a link to the adjudication system that permits a provider to directly enter and submit data related to claims into the payer's system, rather than submitting a transaction. DDE is beneficial to the provider and the system because it does not require the use of formatting data elements. Because the data directly enters the system it can call for only those data elements that are required for all HIPAA claims plus those situational data elements that become required in order to conduct the business. Because DDE enters the SD/MC system directly, it is a 'one claim at a time' claiming process. Other benefits include the capability to incorporate edits to the online entry process, e.g. a blank field for a required element will not be accepted. This type of system also enables a small provider to submit HIPAA compliant claims without excessive costs related to the purchase of additional software. In addition to the 'one claim at a time' issue, other downsides to this process entail the system maintenance required and the possible requirement for help desk personnel to assist individuals to navigate the system.

Partners involved with SD/MC need to determine their policy with regard to continuing to accept paper claims. Paper claims are a human resource intensive way to receive claim related information, however they may be the only way that some providers have of communicating this information. Paper claims must be keyed into a system at some point and they do not always convey all of the information available on standard electronic transactions. Once the system is changed to accept and process a great deal more information than it does currently, it will be necessary to change formats for paper claims, since the existing paper claim will not convey enough information to adjudicate a claim. The CMS1500 and UB92, in their current state, are also not totally compliant with HIPAA data content. Planned future versions of the CMS 1500 and the UB04 will approximate the data content for HIPAA 837 claims, however it is possible that they will not continue compliance once future versions of the 837 are named in Rule. SD/MC partners should be aware, however, that lack of DDE options or the ability to submit paper claims may place burdens on smaller providers and cause them to stop

servicing Medi-Cal patients. This potential loss of available providers—possibly in underserved areas—should be weighed against the administrative burden of handling paper claims.

Along with policies regarding the acceptance of paper claims, SD/MC partners will have to carefully consider their requirement for invoices to accompany claim batches. A signature may be validation of the signatory's responsibility for data content on a claim, but that responsibility is likely enforceable by standard chain of command and the audit trail of each and every submitted electronic claim. These invoices cause considerable payment delays and often demand that individuals along the chain of responsibility make changes to claims that they did not create originally. This practice makes it difficult to assign responsibility for invalid or fraudulent claims.

DMH, ADP, and DHS may choose to find an electronic mechanism to receive data regarding the administrative costs related to county management of SD/MC programs. It is not clear exactly how these costs have been determined in the past but they do not fit in the data elements of a standard electronic claim. Because it is not governed by HIPAA, this data can be exchanged in any manner agreeable to the trading partners. It can, for example, continue to be a paper or electronic invoice that lists these administrative costs and requests payment. It is also possible for the SD/MC system to automatically assign a particular percentage cost to claims submitted by the counties. In this respect, the county would submit claims for services provided. DMH and ADP would determine a percentage of the claim that would apply to administrative services. With the 835, the system would send remittance payment related to the claim and add and adjustment of X% or X dollars with a Claim Adjustment Reason Code such as 94 – Processed in excess of charges. With this mechanism, the system keeps track of all payments made to each county and the adjudication information behind those payments. Cost accounting should be much easier in the end of the year—if it remains a necessary process at all.

6.2 Payment Information

The standardized claim payment transaction is a tool with a wide variety of applications. It is used to return the majority of data that was originally sent on a claim and can accommodate remittance data for an entire batch of claims. The transaction returns charges and payment adjustments for each claim line and for each service line if indicated. Further, the transaction can accommodate up to 6 adjustments for each claim or service line. Once claim adjudication information has been accumulated, the claim payment transaction also enables the addition or subtraction of funds that are not related to individual claims and allows for a reversal and correction of a previous remittance advice. The functionality of this transaction is demonstrated in the following example:

DMH makes an interim payment of 1/12 of the SGF budget to New York County, a sum of $100,000. This payment is made through the SD/MC system so it is accounted for. At the end of the first month, New York County submits 200 claims for $1000 each ($200,000). Ten of these claims are denied because they are duplicates (-$10,000). Further adjustments to 20 of the claims reduce them by $100 each (-$2000). In this scenario, the county will bill $200,000. The bill will be reduced/adjusted by $12,000, so the claim segment of the transaction would list payments due of $188,000. The third section of the payment transaction will then apply the $100,000 that has already been paid but is not related to these particular claims. The resulting remittance to the county will be $88,000.

Because there is so much business functionality available in the payment transaction, it is necessary for the SD/MC to determine how much detail it will require on incoming transactions and how much detail it will be able to process. The system will do all of this processing automatically, so accurate, contextual adjudication criteria is essential. Additionally, the payment is also automatic, so the system must send payment information back to the sender, while sending payment request information to the SCO to complete the payment process. The provider's system will automatically post the remittance information and then marry it with the check or EFT when it arrives from the SCO.

6.3 Claim Status Inquiry and Response

Because the claim and payment process are automatic, it is likely that payment will be received before the provider has the necessity to question the status of the claim, however it is possible that a claim could be suspended for internal issues and the provider might need to check the status of the claim or payment. The HIPAA named transaction for this type of inquiry is the 276 Claim Status Inquiry and the 277 Claim Status Response. These processes are currently managed by telephone, and that process can continue, although it is resource intensive. Any other type of e-mail or electronic inquiry would not be compliant with HIPAA. Mapping for these transactions appears in Appendix A, but final completion of the mapping can only take place once SD/MC has made decisions about the level of detail it can support within the system. The transaction permits detail to be returned about the status of procedure codes submitted, however many systems cannot achieve that level of functionality.

In order to support this transaction, the system must establish mechanisms whereby it tracks submitted claims and payment transactions at various points along the way. Once the provider queries the system by any of the available query criteria, the system must locate the individual claim, determine its status, and return information regarding that particular claim. While 276 transactions can be sent in a batch, they still will

reference individual claims so there is no way to return specific information about the entire batch.

6.4 Code Sets

Code sets can often pose very difficult issues for health plans and providers. Standardization will improve these issues, but the health care delivery system is still some distance from realizing complete standardization. Some code sets still duplicate data, which is an issue that will continually require resolution over a significant period of time. Not only are there medical data code sets, but there are also a host of other code sets referencing race, language, gender, eligibility status, payer types, provider types, etc. Code sets that are internal to the transactions will only change when a new version of the transaction is named, but code sets that are external will change when dictated by the health care organization that manages the code list. For this reason, some code sets may change quarterly, while some may not change for years. A list of internal and external code sets appears in Appendix B and C, and a full listing of the code sets by applicable transaction appears in Appendix D.

For data exchanges, two code set issues are very important. The first is that because of duplicate codes, the code set that works for one entity may not be the code set that is processed by the other—while both code sets are valid. For example, counties would prefer to use Common Procedural Terminology (CPT-4) codes to detail procedures, because they are used by Medicare. DMH and ADP, however, would prefer the use of Healthcare Common Procedural Coding System (HCPCS) codes for those procedures. In many cases these codes explain the same procedures. The system can either crosswalk incoming codes to those used in the system, or the SD/MC partners can establish payment criteria for codes from both sets. The second issue involves the code sets that are valid at specific times in the claim process. Since procedure codes may change quarterly, it is necessary that the incoming claim carry the procedure code that is valid at the time that the service was rendered. For most other codes, that are not medical data code sets, the codes that are used are those that are valid at the time the transaction is submitted. This may cause some significant issues during periods of transition between one named transaction and the next version.

6.5 Decision Support

The intent of HIPAA Administrative Simplification is to create standardization that allows for electronic administrative business processes to be conducted automatically, without human intervention. This means that the system will conduct the transaction without the manual intervention of DMH, ADP or DHS. It becomes critical, then, for this wealth of data to be captured for later review, query or analysis. The SAIC/FOX HIPAA Team determined through interview that few systems available at DMH, ADP, or DHS are

capturing all of the data that is currently available, not to mention data that will be available in the new system. Many individuals requested the availability of this data from claim submission to claim payment. It is clear that systems will need to be enhanced to capture all of the desired data. It will also be very necessary that transition details be worked out between the partners so that data is captured, stored, and retrieved in formats necessary to support the current business processes in place. At some point, business processes may need to change and historical data remains as is currently recorded, while new data reflects the changes enabled by HIPAA compliance. For example, incoming codes for procedures at this time are frequently local codes. The system can take in standard HCPCS or CPT codes but must process them by converting them to the local codes in the system. Business processing and reporting may dictate that data management systems continue to convert the codes into the local codes of the past. This process can continue, but it may also be advantageous for the partners to declare a point in time at which their business processes convert to the standard codes. For general external reporting they may make references to the translation from the new codes to the old, but over time, they will begin to develop and maintain their historical information using the new data structures.

7. Business Process Improvement

Much of these assessment and requirement documents have focused on those issues that are required for HIPAA compliance or are requested as a specific need for partners using the SD/MC system. A significant system enhancement should not be undertaken, however, without careful consideration to *all* of the benefits that are available with use of the HIPAA transactions. Throughout interviews and review of extensive documentation, issues have arisen that imply that much more could be done regarding program development, service delivery, or payment processes if only more information were available. The SAIC/FOX HIPAA Team recommends that committees of appropriate staff from DHS, DMH, ADP and the counties/providers be appointed to review all of the transactions to determine what business process improvements could be obtained with the available data. Once that process is completed, the committees should be charged with determining the level of effort to obtain the information (both to supply it and to retrieve it) balanced against the gain. Finally, these committees should work to determine how the information can be best used to improve patient service delivery or the eventual outcomes for that care. Table12, below, is a list of some of the available data elements or segments that were stated or implied from work conducted to complete this deliverable.

Table 12. Business Process Improvement Opportunities

Business Process Improvement Opportunities				
ID	Description of Business Improvement Opportunity	**Req. Org**[14]	**HIPAA Trans**	Comment or Issues
E1	Mechanism to identify transactions within a provider system	DMH A	837I and 837P	Reference ID – assigned by originator to identify the transaction in the system or Claim Submitter ID to identify the patient account number in his/her system
E2	Identify the submitter as either a direct provider or a county	ADP I	837I and 837P	Submitter or Organization Name
E3	Manage provider information once NPI is required	ADP I	837I and 837P	ID code qualifier and ID code that recognizes current provider ID and ultimately NPI

[14] This is an indicator of the organization that either specifically requested a requirement or that the requirement was developed through documentation or meetings with the organization listed. Key: A = Assessment, I = Interview, L = Letters and Notices to providers.

Business Process Improvement Opportunities				
ID	Description of Business Improvement Opportunity	**Req. Org**[14]	**HIPAA Trans**	Comment or Issues
E4	Determine qualifications of providers	DMH I	837I and 837P	Taxonomy code identifies the provider type and specialty as well as subspecialty information.
E5	Allow counties to be pay-to providers to act as billing agents for subcontracting providers	ADP I	837I and 837P	Pay-to Provider loop enables the county to be the payee while submitting a claim on behalf of another rendering provider
E6	Conduct Coordination of Benefits (COB) electronically from payer to payer and provider to payer	DMH I	837I and 837P	COB fields carry information from previous payers and may be completed by current payer if to be forwarded to additional payers. Consider the Payer to Payer elements from Version 4050 to enable pay and chase collections.
E7	Patient information, such as occurrence of pregnancy facilitates different payment logic of claims	ADP A	837I and 837P	Use pregnancy indicator or additional diagnoses to establish the pregnancy and enable new payment logic
E8	Determine patient current address which may be different than on eligibility file	DMH A	837I and 837P	Patient/Subscriber address field enables the patient current address to be submitted. May differentiate between a county of residence or county of responsibility
E9	Electronically determine the appropriate county for payment responsibility when patient seeks care out of county	DMH A	837I and 837P	Responsible Party Name field may establish the county that is responsible if patient is seeking care out of county. Might avoid or assist the contractor that currently manages this process
E10	Determine if professional services provided in institutions	ADP I	837I and 837P	Place of service codes can be applied at either the claim or service line. Codes represent facilities such as hospitals, residential treatment or nursing homes
E11	Determine that provider signature is on file in the office rather than sending with each claim	ADP I DMH I	837I and 837P	Provider Signature on File indicator can be sent with each claim and can be audited at some other time.
E12	Determine specific contractual arrangements with some counties (San Mateo)	DMH I	837I and 837P	Contract information is available on the claim to differentiate special payment structures
E13	Allow counties to purchase services if they are not determined to be health plans	ADP I	837I and 837P	Purchased Service can be indicated on the claim and service line level

Business Process Improvement Opportunities				
ID	Description of Business Improvement Opportunity	**Req. Org**[14]	**HIPAA Trans**	Comment or Issues
E14	Allow flexibility for any new state mandates	DHS ITSD	837I and 837P	Maintain availability of the K3 field for new state mandates
E15	Allow providers to submit additional information they feel will enable better processing	ADP L DMH L	837I and 837P	Recognize the NTE Note field, however its use should be discouraged as it will require manual processing.
E16	Enable electronic submission of additional EPSDT information that may be used for reporting or research	ADP L DMH L	837I and 837P	Additional program information for EPSDT can be carried in the CRC segment. This segment is required if the claim is for EPSDT services.
E17	Services can be linked to specific diagnoses	ADP A	837I and 837P	Enable the diagnosis code pointer to enable the provider to indicate that specific line item services relate to a specific diagnosis, where more than one diagnosis is submitted
E18	There may be a need to determine the relationship for youth in the Healthy Families SED program	DMH L	837I and 837P	Relationship codes can indicate a child who is a foster child, adopted child, or other relationship that may be specific during treatment phases.
E19	Enable the sending of standard supporting documentation electronically, i.e. treatment plans, certification invoice documents, etc.	DMH I ADP I	837I and 837P	Form Identifier code allows for these standard documents to be sent electronically
E20	Allow provider to request a paper EOB in addition to or instead of an electronic one	DMH I	837I and 837P	EOB paper indicator can be supplied by the provider to request this change
E21	A variety of information can be transmitted on institutional claims regarding occurrences, values of processes and conditions – taken from UB-92 paper formats	DMH L ADP L	837 I	Enable the processing of occurrence codes, value codes and condition codes that are available on the institutional claim or the paper UB-92 claim The condition code field is where EPSDT information is carried on the 837I claim
E22	Provider information is different in institutions than in clinics or office practices	DMH L ADP L	837I	Enable information regarding Attending Physician, Referring Providers, or Other physicians as deemed necessary by programs

Business Process Improvement Opportunities				
ID	Description of Business Improvement Opportunity	**Req. Org**[14]	**HIPAA Trans**	Comment or Issues
E23	Certain Medicare payment information is carried in specific locations	DMH L ADP L	837I	Medicare completes the Medicare Inpatient Adjudication information (MIA) or Medicare Outpatient Adjudication Information (MOA) to supply this information to secondary payers.
E24	Counties want a payment date that is different than the service date	County Meeting	835	The 835 carries a Check Issue or EFT Date
E25	Systems should be able to post payment data electronically	DMH A	835	The Reassociation Trace Number is the check or EFT number to enable the alignment of payment information with the actual payment traveling by a different route.
E26	For tracking purposes in the 276/277 transaction, it may be necessary to locate the status of claims in process	DHS ITSD	835	The 835 carries a production date that references that date of the adjudication run if the 835 is not produced at that time.
E27	Information is returned to counties in aggregate; would like information broken down by provider	County Meeting	835	Information on specific direct providers can be returned in the 835 to the pay-to provider (the county). The TS3 is generally used for Medicare but can be used in this circumstance as well
E29	Units of service may be adjusted by ADP or DMH in the adjudication process	DMH A	835	Adjustments to units of service can be returned in CAS segments at either the claim or service line level to enable submitters to know how payment was determined
E30	Third party payment information is not used in claim processing	DMH I ADP I	835	The 835 enables return of third party payments as they affect payments by ADP or DMH
E32	Current EOB information does not differentiate between institutional and professional type claims	DMH I ADP I	835	Service information can include procedure codes for professional claims and revenue codes for institutional claims
E33	Information regarding specific claim adjustments may be more generic than currently used	DMH A	835	The 835 enables the use of remark codes to further explain claim or service line adjustments; additional may need to be requested.
E34	Adjustments to payments that are not specific to the claim are not explained in current EOBs	County Meeting	835	PLB segments allow for adjustments to payments that are not related to the claim information being returned. Such adjustments might include: interim settlement payments, overpayment recoveries, or retroactive adjustments.

Business Process Improvement Opportunities				
ID	Description of Business Improvement Opportunity	**Req. Org**[14]	**HIPAA Trans**	Comment or Issues
E35	Dates in claims are not always sent or used by the system	ADP I DMH I	837 I and 837 P	Some dates are optional. Most are situational and these situations occur occasionally. The system should use and process such dates for better adjudication information. Time of service would enable better duplication checking and fraud abuse
E36	Medicare only processes CPT codes which causes problems with crossovers	County meeting	837I and 837P	SD/MC can choose to crosswalk such codes internally to enable the crossover claim or it can set up payment logic on the CPT code as well as the HCPCS codes to permit the system to adjudicate the crossover information.
E37	Counties would like increased special population data	County meeting	834	This information is not available on any transaction other than the 834, nor can it be transmitted on any existing transaction. If the data is collected in the MEDS system, however, a special report from MEDS to the counties could communicate that information. Aggregate, de-identified data would be the most compliant with HIPAA privacy.
E38	ICD-9 codes have 5 digits but counties would like the use of ICD-10, which are enabled in later versions of the transactions	County meeting	837I and 837P	While building flexibility into the new system, SD/MC might give consideration to increasing the diagnosis code field to 6 digits to accommodate future versions.
E39	Want a better way to share information between counties. (Prev. D15)	ADP DMH DHS	270/271	The beginning process is an eligibility inquiry on each client. This can return valuable information regarding the benefits available and the permanent address of the client for tracking purposes. The details of these transactions are outside the scope of this project.
E40	Allow billing across months and fiscal years.	DMH I	837P, 837I and 835	Although there are no barriers in the HIPAA transactions, there may be business constraints that limit the flexibility of billing across months.

Business Process Improvement Opportunities				
ID	Description of Business Improvement Opportunity	**Req. Org**[14]	**HIPAA Trans**	Comment or Issues
E41	Improve edits within the system to detect complex fraud or abnormal billing patterns; current edits do detect some duplicate claims and deny similar services rendered to the same patient on the same day.	DMH ADP	837I and 837P	HIPAA provides the opportunity to increase fraud by making more information available and making it easier to compare utilization among programs.

8. Staffing Model Changes

It is very difficult to propose staffing model changes prior to making recommendations for remediation. These suggestions are very general and should be taken only as possible options for different distribution of staff.

8.1 Information Technology (IT)

Under any scenario, the SD/MC system will need continual upgrading to maintain pace with changes in HIPAA requirements, particularly in terms of updating code sets and affected edits or other processes. This upgrading could be exceedingly labor intensive even after significant system re-engineering occurs to achieve HIPAA at this time. Even though a new system might be more efficient electronically, there will still be needs for maintenance and help desk type staff. There may, however, be some changes that seem appropriate for consolidation of some IT staff. The current system requires separate staff at DHS, DMH and ADP to manage and navigate the various systems that have been necessary to secure claim payment. There could be advantages to having one decision support system which contains all of the data from claims, encounters, interim payments, claim payments, etc. This system would need to be accessible by multiple program persons, and queries could be made according to the needs of that program.

Should partners involved in the SD/MC system determine a desire to create a DDE mechanism for claim submission, then IT staff would be necessary to create and maintain such a system. Again, the system will need upgrading at any time that HIPAA standards change, or code systems that are included as part of the DDE system change. User issues will probably be the biggest burden with this type of system, as many providers will want to have numbers to call if the system does not perform as planned.

8.2 Accounting and Contract Management Services

At the current time, many staff are involved with reviewing invoices, comparing those invoices to claim batches, researching FFP levels, monitoring budgets, etc., before claims result in final payment. HIPAA Administrative Simplification would suggest that the system be programmed to manage these details. While fewer individuals may handle the actual claim and invoice before adjudication, it is probable that a similar number of individuals may still be necessary to manage these details from the program perspective. What will be different is that the system manages the payment process, while individuals take the final adjudication and payment information to manage the program. Accounting staff at ADP, DHS, and DMH may need to assure that FFP is available more timely for payment, and contract managers overseeing the Interagency

Agreements will still need to assure that programs remain within their respective budgets. The automation of the system, however should provide more current data that enables these staff to predict cash flow directions and make program decisions earlier.

8.3 Program and Quality Improvement

The greatest advantage to a more automated system is the freeing of resources to monitor services and plan program changes that benefit the clients. At this point, the SD/MC system is extremely labor intensive but that labor is available only to assure payment, not to improve service delivery. Increasing the amount of data that is available and the speed at which that data is available to program staff can only serve to help them make more informed decisions that improve patient care. If a HIPAA compliant system also improves communication between DHS, DMH, ADP and their county service delivery partners as well as expediting the payment for such services, the process will have indeed been improved.

Appendix A: Mapping of 276 and 277 Transactions

276 Transaction

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
	ST		R	Transaction set Header	Health Care Claim Status Request				
		ST01	R	Transaction Set Identifier Code		276 HC Claim Status Request		3	
		ST02	R	Transaction Set Control #			ST02 must equal SE02	9	Check for complete transaction
	BHT		R	Beginning of Hierarchical Transaction					
		BHT01	R	Hierarchical Structure Code		0010	Information Source, Information Receiver, Provider of Service, Subscriber, Dependent	4	Accept 0010
		BHT02	R	Transaction Set Purpose Code		13 Request		2	Accept 13
		BHT03	NU						
		BHT04	R	Date	Transaction set Creation Date	CCYYMMDD	Date transaction was created within the business system	8	Accept 8 digit date
		BHT05	NU						
		BHT06	NU						

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
2000A	HL		R	Information Source Level			The information source is the Payer		
		HL01	R	Hierarchical ID Number			Unique alphanumeric number for each occurrence of the HL	12	Accept HL from provider
		HL02	NU	Hierarchical Parent ID number				12	
		HL03	R	Hierarchical Level Code		20 Information Source		2	Accept 20
		HL04	R	Hierarchical Child Code		1 additional subordinate HL data segment in this hierarchical structure		1	
2100A	NM1		R	Payer Name					
		NM101	R	Entity Identifier Code		PR Payer		3	Accept PR
		NM102	R	Entity Type Qualifier		2 Non person entity		1	Accept 2

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
		NM103	R	Name Last or Organization Name	Payer name		Will be required until Plan ID is active	35	Accept and route to correct payer - ADP or DMH
		NM104	NU	Name First					
		NM105	NU	Name Middle					
		NM106	NU	Name Prefix					
		NM107	NU	Name Suffix					
		NM108	R	Identification Code Qualifier			Plan ID will be required	2	Accept Plan qualifier - change to Plan ID when required. It is recommended to use a code (21) from the Health Industry Number code source 121
		NM109	R	Identification Code Qualifier	Payer Identifier		National Plan ID	80	Until Plan ID, this can be any code assigned by Health Industry Number code source or other code appropriate to identify ADP or DMH
		NM110	NU	Entity Relationship code					

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
		NM111	NU	Entity Identifier Code					
2100A	PER		S	Payer Contact Information					
		PER01	R	Contact Function Code	Information Contact	IC		2	Can supply a contact person if the payer chooses.
		PER02	S	Name	Payer Contact Name		Specific contact person name	80	
		PER03	R	Communication Number Qualifier		ED, EM, TE	Required When PER04 is used	2	
		PER04	R	Communication Number	Payer contact communication number		Use to communicate area codes, local exchanges and telephone #. Use PER06 for extension	80	
		PER05	S	Communication Number Qualifier		EX Telephone extension	Required when PER06 is used	2	
		PER06	S	Communication Number	Payer contact communication number		Use for telephone extensions only	80	
		PER07	S	Communication Number Qualifier		EX, FX	Extension or Fax. Required when PER08 is used	2	
		PER08	S	Communication Number	Payer contact communication number			80	
		PER09	NU	Contact Inquiry Reference					
2000B	HL		R	Information Receiver Level			Information Receiver is the entity sending the transaction		

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
		HL01	R	Hierarchical ID Number				12	Accept HL from transaction
		HL02	R	Hierarchical Parent ID number				12	Accept 1
		HL03	R	Hierarchical Level Code		21 Info receiver		2	Accept 21
		HL04	R	Hierarchical Child Code		1		1	Accept 1
2100B	NM1		R	Information Receiver Name					
		NM101	R	Entity Identifier Code		41 submitter		3	Accept 41
		NM102	R	Entity Type Qualifier	Person or Non-person	1 or 2		1	Accept 1 or 2
		NM103	R	Name Last or Organization Name				35	Accept name of provider or county name
		NM104	S	Name First			First Name required when NM102 is 1 - person	25	First name required if receiver is a provider person
		NM105	S	Name Middle			required if additional info needed to identify. Recommended if entity type is person	25	
		NM106	S	Name Prefix				10	
		NM107	S	Name Suffix				10	

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
		NM108	R	Identification Code Qualifier		46 - ETIN, FI -TIN, XX - NPI	Will be required when NPI is mandated	2	Probably accept FI
		NM109	R	Identification Code Qualifier	Info receiver id number	NPI		80	Taxpayer Identification Number or Electronic Transmitter Identification Number - Field 011 - 014 on claim
		NM110	NU	Entity Relationship code					
		NM111	NU	Entity Identifier Code					
2000C	HL		R	Service Provider Level					
		HL01	R	Hierarchical ID Number				12	Accept HL sent - probably 3
		HL02	R	Hierarchical Parent ID number				12	Accept HL sent - probably 2
		HL03	R	Hierarchical Level Code		19 provider of service		2	Accept 19
		HL04	R	Hierarchical Child Code		1		1	Accept 1

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
2100C	NM1		R	Provider Name					
		NM101	R	Entity Identifier Code		1P Provider	This is the billing provider from the original submitted claim	3	Accept 1P
		NM102	R	Entity Type Qualifier		1 or 2		1	Accept 1 0r 2, usually 2
		NM103	R	Name Last or Organization Name	Provider Last or organization name			35	Provider name or county name
		NM104	S	Name First			Required if value in NM102 is person	25	First name required if receiver is a provider person
		NM105	S	Name Middle			Middle name or initial is required when NM102 is 1 and the person has a middle name or initial	25	
		NM106	S	Name Prefix				10	
		NM107	S	Name Suffix				10	
		NM108	R	Identification Code Qualifier		FI, SV, XX	Required if NPI is mandated for use	2	For now will generally be FI or SV
		NM109	R	Identification Code Qualifier	Provider identifier		NPI	80	May be fields 011-014 or may be different assigned provider number
		NM110	NU	Entity Relationship code					

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
		NM111	NU	Entity Identifier Code					
2000D	HL		R	Subscriber Level					
		HL01	R	Hierarchical ID Number			Use if subscriber and patient are the same person	12	Accept assigned HL - usually 4
		HL02	R	Hierarchical Parent ID number				12	Accept assigned HL - usually 3
		HL03	R	Hierarchical Level Code		22 subscriber		2	Accept 22
		HL04	R	Hierarchical Child Code		0 or 1	0- no subordinate HL segments 1 additional subordinate HL segments	1	Accept assigned, Usually 0
2000D	DMG		S	Subscriber Demographic Information			Required when subscriber is the patient		
		DMG01	R	Date Time Period Format Qualifier	Date expressed as CCYYMMDD	D8		3	Accept D8
		DMG02	R	Date Time Period Format Qualifier	Subscriber Birth Date			35	Birthdate from MEDS or 062-065
		DMG03	R	Gender Code		F. M. U		1	66
		DMG04	NU						
		DMG05	NU						
		DMG06	NU						

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
		DMG07	NU						
		DMG08	NU						
		DMG09	NU						
2100D	NM1		R	Subscriber Name					
		NM101	R	Entity Identifier Code		IL, QC	IL Insured or subscriber, QC Patient - use this code only when the subscriber is the patient	3	Accept QC
		NM102	R	Entity Type Qualifier		1 or 2	Patient is a '1' person	1	Accept 1
		NM103	R	Name Last or Organization Name	Subscriber Last Name			35	025-038
		NM104	S	Name First			Required when value in NM102 is 1 and the person has a first name	25	Gap in SD/MC
		NM105	S	Name Middle			Required when value in NM102 is 1 and the person has a middle name	25	Gap in SD/MC
		NM106	S	Name Prefix				10	
		NM107	S	Name Suffix				10	
		NM108	R	Identification Code Qualifier		24, MI, ZZ	Employer ID #, Member ID #, Mutually defined	2	Accept MI
		NM109	R	Identification Code Qualifier	subscriber Identifier			80	048 - 061

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
		NM110	NU	Entity Relationship code					
		NM111	NU	Entity Identifier Code					
2200D	TRN		R	Claim Submitter Trace Number			Use is required if subscriber is patient		
		TRN01	R	Trace Type Code	Current Transaction trace number	1		2	Accept 1
		TRN02	R	Reference Identification	Trace Number, Patient Account Number		This number from CLM01 in original transaction	30	Accept # from CLM01 in 837
		TRN03	NU						
		TRN04	NU						
2200D	REF		S	Payer Claim Identification Number					
		REF01	R	Reference Identification Qualifier	Payer's Claim Number	1K		3	Accept 1K
		REF02	R	Reference Identification	Payer Claim Control Number	ICN, DCN, CCN	Submit this element if the payer supplied it previously	30	If SD/MC assigns a distinct number to locate a claim, that should be sent in 835 or U277 and my be received here.
		REF03	NU						
		REF04	NU						

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
2200D	REF		S	Institutional Bill Type Identification			Segment is the institutional Type of Bill submitted on the original claim		
		REF01	R	Reference Identification Qualifier	Billing Type	BLT		3	Accept BLT
		REF02	R	Reference Identification	Bill Type Identifier		UB92 - record 40 - 4, 837 CLM-05, UB92 paper form locator 4. Required for institutional claims	30	Accept data from CLM05 on 837I
		REF03	NU						
		REF04	NU						
2200D	REF		S	Medical Record Identification					
		REF01	R	Reference Identification Qualifier	Medical Record Identification	EA	Medical Record identification Number	3	Accept EA
		REF02	R	Reference Identification	Medical Record Number		Found on UB92 record 20 filed 25, Found on 837 CLM-05, found on UB92 paper form locator 23. Total REFs in this segment less than or equal to three.	30	039 - 047
		REF03	NU						
		REF04	NU						
2200D	REF		S	Group Number					

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
		REF01	R	Reference Identification Qualifier		LU	Location number	3	
		REF02	R	Reference Identification	Group Number			30	Medicaid doesn't usually have a group number
		REF03	NU						
		REF04	NU						
2200D	AMT		S	Claim Submitted Charges					
		AMT01	R	Amount Qualifier Code	Total Submitted Charges	T3	UB92 - Revenue Code0 001 and record 90, UB92 paper form - Revenue code 0001, 837 CLM02 professional, Revenue Code 0001 institutional,	3	Accept T3
		AMT02	R	Monetary Amount	Total Claim Charge Amount			18	093 - 100
		AMT03	NU						
2200D	DTP		S	Claim Service Date					
		DTP01	R	Date/Time Qualifier	Claim statement period Start	232	Dates of service submitted on the original claim	3	Accept 232
		DTP02	R	Date Time Period Format Qualifier		RD8 date range	If the date is a single date of service, the begin date equals the end date	3	Accept RD8
		DTP03	R	Date Time Period				35	073-082

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
2210D	SVC		S	Service Line Information			Use to request status information about a service line		
		SVC01	R	Composite Medical Procedure Identifier					
		SVC01-1	R	Product or Service ID qualifier		HC, NU, ID	Contains the procedure code of the adjudicated claim. If the adjudicated code is not known then SVC01 will contain the original submitted procedure code.	2	HC = HCPCS or CPT code, NU = Revenue Code, ID = ICD - Procedure code (rarely used)
		SVC01-2	R	Product Service ID	Service Identification Code		If the value in SVC01-1 is NU, then this element is an NUBC Revenue code. If a value is present here, then SVC04 is not used	48	084-085 - SD/MC has a gap relating to 5 digit procedure codes
		SVC01-3	S	Procedure Modifier			Required if submitted on the original claim service line	2	Gap in SD/MC
		SVC01-4	S	Procedure Modifier			Required if submitted on the original claim service line	2	Gap in SD/MC
		SVC01-5	S	Procedure Modifier			Required if submitted on the original claim service line	2	Gap in SD/MC
		SVC01-6	S	Procedure Modifier			Required if submitted on the original claim service line	2	Gap in SD/MC
		SVC01-7	NU	Description					

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
		SVC02	R	Monetary Amount	Line Item Charge Amount		Original submitted charge	18	Gap in SD/MC as service line charges are not separated from claim charges
		SVC03	NU	Monetary Amount					
		SVC04	S	Product Service ID	Revenue Code			48	Revenue code here if another code is used in SVC01-2
		SVC05	NU	Quantity					
		SVC06	NU	Composite Medical Procedure Identifier					
		SVC07	S	Quantity	Original units of service count		These are the submitted units of service. The default is 1 unit. This element is required when the submitted units are greater than 1	15	090 - 092 Gap exists when units of service and units of time are different.
2210D	REF		S	Service Line Item Identification					

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
		REF01	R	Reference Identification Qualifier	Line Item Control Number	FJ	Use this segment if the subscriber is the patient, Required when available from the original claim. When the Information receiver is the provider, this is required when the number was assigned by the provider on the original claim.	3	Accept FJ
		REF02	R	Reference Identification	Line Item Control Number			30	This is LX from the original 837 - Gap for SD/MC
		REF03	NU						
		REF04	NU						
2210D	DTP		R	Service Line Date					
		DTP01	R	Date/Time Qualifier		472	Service	3	Accept 472
		DTP02	R	Date Time Period Format Qualifier		RD8 Date Range	Range of dates expressed in format CCYYMMDD-CCYYMMDD, if the date is a single date of service, the begin date equals the end date	3	Accept RD8
		DTP03	R	Date Time Period	Service Line Date			35	Gap to differentiate service line from claim line
2000E	HL			Dependent Level			Not used		

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC Field
	SE		R	Transaction Set Trailer					
		SE01	R	Number of Included Segments				10	Count segments and compare to this included number
		SE02	R	Transaction Set Control Number			Data value in SE02 must be identical to ST02	9	Compare to ST02

277 Transaction

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
	ST		R	Transaction set Header	Health Care Claim Status Notification				
		ST01	R	Transaction Set Identifier Code		277 Health Care Claim Status Notification		3	Send 277
		ST02	R	Transaction Set Control #			ST02 must equal SE02	9	Set control number
	BHT		R	Beginning of Hierarchical Transaction					

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		BHT01	R	Hierarchical Structure Code		0010	Information Source, Information Receiver, Provider of Service, Subscriber, Dependent	4	Send 0010
		BHT02	R	Transaction Set Purpose Code		08 Status		2	Send 08
		BHT03	R	Reference Identification	Originator application transaction identifier			30	SD/MC originated number - Gap
		BHT04	R	Date	Transaction set Creation Date	CCYYMMDD	Date transaction was created within the business system	8	SD/MC originated date - Gap
		BHT05	NU						
		BHT06	R	Transaction Type Code		DG Response		2	Send DG
2000A	HL		R	Information Source Level			The information source is the Payer		
		HL01	R	Hierarchical ID Number			Unique alphanumeric number for each occurrence of the HL	12	Send 01
		HL02	NU	Hierarchical Parent ID number				12	Send 00
		HL03	R	Hierarchical Level Code		20 Information Source		2	Send 20

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		HL04	R	Hierarchical Child Code		1 additional subordinate HL data segment in this hierarchical structure		1	Send 1
2100A	NM1		R	Payer Name					
		NM101	R	Entity Identifier Code		PR Payer		3	Send PR
		NM102	R	Entity Type Qualifier		2 Non person entity		1	Send 2
		NM103	R	Name Last or Organization Name	Payer name		Will be required until Plan ID is active	35	Send Payer Name - ADP or DMH - Gap
		NM104	NU	Name First					
		NM105	NU	Name Middle					
		NM106	NU	Name Prefix					
		NM107	NU	Name Suffix					
		NM108	R	Identification Code Qualifier			Plan ID will be required	2	Send code number from Code set 121 or other code set developed - Gap

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		NM109	R	Identification Code Qualifier	Payer Identifier		National Plan ID	80	Send actual code - Gap
		NM110	NU	Entity Relationship code				2	
		NM111	NU	Entity Identifier Code				3	
2100A	PER		S	Payer Contact Information			Telephone numbers are expressed without hyphens		
		PER01	R	Contact Function Code	Information Contact	IC		2	Send IC if desired
		PER02	S	Name	Payer Contact Name		Specific contact person name	80	Send contact persons name
		PER03	R	Communication Number Qualifier		ED, EM, TE	Required When PER04 is used	2	Send ED =EDI access number, EM = e-mail, TE = telephone number
		PER04	R	Communication Number	Payer contact communication number		Use to communicate area codes, local exchanges and telephone #. Use PER06 for extension	80	Send telephone number
		PER05	S	Communication Number Qualifier		EX Telephone extension	Required when PER06 is used	2	Send EX
		PER06	S	Communication Number	Payer contact communication number		Use for telephone extensions only	80	Send Extension number

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		PER07	S	Communication Number Qualifier		EX, FX	Extension or Fax. Required when PER08 is used	2	Send Additional extension or Fax code
		PER08	S	Communication Number	Payer contact communication number			80	Send extension or fax number
		PER09	NU	Contact Inquiry Reference					
2000B	HL		R	Information Receiver Level			Information Receiver is the entity receiving the transaction		
		HL01	R	Hierarchical ID Number				12	Send 02
		HL02	R	Hierarchical Parent ID number				12	Send 01
		HL03	R	Hierarchical Level Code		21 Info receiver		2	Send 21
		HL04	R	Hierarchical Child Code		1		1	Send 1
2100B	NM1		R	Information Receiver Name					
		NM101	R	Entity Identifier Code		41 submitter		3	Send 41
		NM102	R	Entity Type Qualifier	Person or Non-person	1 or 2		1	Send 1 or 2
		NM103	R	Name Last or Organization Name				35	Send provider or county name

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		NM104	S	Name First			First Name required when NM102 is 1 - person and person has a first name	25	Send first name if provider - Gap
		NM105	S	Name Middle			required if additional info needed to identify. Recommended if entity type is person	25	Send if available
		NM106	S	Name Prefix				10	
		NM107	S	Name Suffix				10	
		NM108	R	Identification Code Qualifier		ETIN, TIN, NPI	Will be required when NPI is mandated	2	Send 46 - ETIN, FI - TIN, XX - NPI
		NM109	R	Identification Code Qualifier	Info receiver id number	NPI		80	Send Taxpayer Identification Number or Electronic Transmitter Identification Number - Field 011 - 014 on claim - Gap as none of these numbers are kept

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		NM110	NU	Entity Relationship code					
		NM111	NU	Entity Identifier Code					
2000C	HL		R	Service Provider Level					
		HL01	R	Hierarchical ID Number				12	Send 03
		HL02	R	Hierarchical Parent ID number				12	Send 02
		HL03	R	Hierarchical Level Code		19 provider of service		2	Send 19
		HL04	R	Hierarchical Child Code		1		1	Send 1
2100C	NM1		R	Provider Name					
		NM101	R	Entity Identifier Code		1P Provider	This is the billing provider from the original submitted claim	3	Send 1P
		NM102	R	Entity Type Qualifier		1 or 2		1	Send 1 or 2
		NM103	R	Name Last or Organization Name	Provider Last or organization name			35	Send provider or county name
		NM104	S	Name First			Required if value in NM102 is person and person has a first name.	25	Send first name if provider - Gap
		NM105	S	Name Middle			Middle name or initial is required when NM102 is 1 and the person has a middle name or initial	25	Send if available
		NM106	S	Name Prefix				10	

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		NM107	S	Name Suffix				10	
		NM108	R	Identification Code Qualifier		FI, SV, XX	Required if NPI is mandated for use	2	Send FI, SV, XX
		NM109	R	Identification Code Qualifier	Provider identifier		NPI	80	Send provider number - Gap as none of these numbers is kept
		NM110	NU	Entity Relationship code					
		NM111	NU	Entity Identifier Code					
2000D	HL		R	Subscriber Level					
		HL01	R	Hierarchical ID Number			Use if subscriber and patient are the same person	12	Send 04
		HL02	R	Hierarchical Parent ID number				12	Send 03
		HL03	R	Hierarchical Level Code		22 subscriber		2	Send 22
		HL04	R	Hierarchical Child Code		0 or 1	0- no subordinate HL segments 1 additional subordinate HL segments	1	Send 0
2000D	DMG		S	Subscriber Demographic Information			Required when subscriber is the patient		
		DMG01	R	Date Time Period Format Qualifier	Date expressed as CCYYMMDD	D8		3	Send D8

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		DMG02	R	Date Time Period Format Qualifier	Subscriber Birth Date			35	Send Birthdate - Gap as birthdates are kept as month and year
		DMG03	R	Gender Code		F. M. U		1	Return Gender as sent
		DMG04	NU						
		DMG05	NU						
		DMG06	NU						
		DMG07	NU						
		DMG08	NU						
		DMG09	NU						
2100D	NM1		R	Subscriber Name					
		NM101	R	Entity Identifier Code		IL, QC	IL Insured or subscriber, QC Patient - use this code only when the subscriber is the patient	3	Send QC
		NM102	R	Entity Type Qualifier		1 or 2	Subscriber is '1' person	1	Send 1
		NM103	R	Name Last or Organization Name	Subscriber Last Name			35	Send 025-038
		NM104	S	Name First			Required when value in NM102 is 1 and the person has a first name	25	Send First name of patient - Gap

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		NM105	S	Name Middle			Required when value in NM102 is 1 and the person has a middle name	25	Send middle name of patient if known
		NM106	S	Name Prefix				10	
		NM107	S	Name Suffix				10	
		NM108	R	Identification Code Qualifier		24, MI, ZZ	Employer ID #, Member ID #, Mutually defined	2	Send MI
		NM109	R	Identification Code Qualifier	subscriber Identifier			80	048-061 or 312-320
		NM110	NU	Entity Relationship code					
		NM111	NU	Entity Identifier Code					
2200D	TRN		R	Claim Submitter Trace Number			Use is required if subscriber is patient		
		TRN01	R	Trace Type Code	Referenced Transaction Trace Numbers	2		2	Send 2
		TRN02	R	Reference Identification	Trace Number, Patient Account Number		This number from CLM01 in original transaction	30	Return TRN02 from 276
		TRN03	NU						
		TRN04	NU						
2200D	STC		R	Claim Level Status Information			Required if Subscriber is the Patient		
		STC01	R	Health Care Claim Status					
		STC01-1	R	Industry Code	Health Care Claim Status Category Code		Category Code. Use code source 507	30	Gap

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		STC01-2	R	Industry Code	Health Care Claim Status Code		Status Code. Use code source 508	30	Gap
		STC01-3	S	Entity Identifier Code		Many codes in list	Further Modified the status code in STC01-2. Required if additional detail applicable to claim status is needed to clarify the status and the payer's system supports this level of detail.	3	Gap
		STC02	R	Date	Status Information Effective Date		Effective Date of Status	8	Return date status determined - Gap
		STC03	NU	Action Code				2	
		STC04	R	Monetary Amount	Total Claim Charge Amount		Amount of submitted charges	18	Return submitted charges from 276
		STC05	R	Monetary Amount	Claim Payment Amount		Use this element for the claim paid amount. This amount must be zero if the adjudication process is not complete. May change based on claims processing instructions, i.e.: splitting of claims.	18	Send 101-108

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		STC06	S	Date	Adjudication or Payment Date		Date of denial or payment. Use this date if the payment determination is complete	8	Send adjudication or payment date - Gap
		STC07	S	Payment Method Code			Will be used when the claim has a dollar payment to the provider of service	3	Use codes from 835 payment, e.g. CHK, NON, ACH, etc. - Gap
		STC08	S	Date	Check issue or EFT Date			8	Send date of check or EFT - Gap
		STC09	S	Check Number	Check or EFT Trace Number		Required with a finalized and PAID claim when the entire claim was paid using a single check or EFT. Not used with Pending or Rejected claims. If the payment is EFT, this number is the trace number.	16	From 835 - Gap
		STC10	S	Health Care Claim Status			Use this element if a second claim status is needed		
		STC10-1	R	Industry Code	Health Care Claim Status Category Code		Category Code. Use code source 507	30	Situational - may use if more than one claim status code is necessary

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		STC10-2	R	Industry Code	Health Care Claim Status Code		Status Code. Use code source 508	30	
		STC10-3	S	Entity Identifier Code		Many codes in list	Further Modified the status code in STC01-2. Required if additional detail applicable to claim status is needed to clarify the status and the payer's system supports this level of detail.	3	
		STC11	S	Health Care Claim Status			Use this element if additional claim status is needed		
		STC11-1	R	Industry Code	Health Care Claim Status Category Code		Category Code. Use code source 507	30	Additional Claim status codes
		STC11-2	R	Industry Code	Health Care Claim Status Code		Status Code. Use code source 508	30	
		STC11-3	S	Entity Identifier Code		Many codes in list	Further Modified the status code in STC01-2. Required if additional detail applicable to claim status is needed to clarify the status and the payer's system supports this level of detail.	3	
		STC12	NU	Free Form Text					
2200D	REF		S	Payer Claim Identification Number			Examples include ICN, CCN, DCN		
		REF01	R	Reference Identification Qualifier	Payer's Claim Number	1K		3	Send 1K

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		REF02	R	Reference Identification	Payer Claim Control Number	ICN, DCN, CCN	Submit this element if the payer supplied it previously	30	Send SD/MC generated id number - Gap
		REF03	NU						
		REF04	NU						
2200D	REF		S	Institutional Bill Type Identification			Segment is the institutional Type of Bill submitted on the original claim		
		REF01	R	Reference Identification Qualifier	Billing Type	BLT		3	Send BLT
		REF02	R	Reference Identification	Bill Type Identifier		UB92 - record 40 - 4, 837 CLM-05, UB92 paper form locator 4. Required for institutional claims	30	Return from 276
		REF03	NU						
		REF04	NU						
2200D	REF		S	Medical Record Identification			Medical record number from original claim and should be returned when available.		
		REF01	R	Reference Identification Qualifier	Medical Record Identification	EA	Medical Record identification Number	3	Send EA

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		REF02	R	Reference Identification	Medical Record Number		Found on UB92 record 20 filed 25, Found on 837 CLM-05, found on UB92 paper form locator 23. Total REFs in this segment less than or equal to three.	30	Return from original claim - 039 - 047
		REF03	NU						
		REF04	NU						
2200D	DTP		S	Claim Service Date					
		DTP01	R	Date/Time Qualifier	Claim statement period Start	232	Dates of service submitted on the original claim	3	Send 232
		DTP02	R	Date Time Period Format Qualifier		RD8 date range	If the date is a single date of service, the begin date equals the end date	3	Send RD8
		DTP03	R	Date Time Period				35	Send 073 - 078
2220D	SVC		S	Service Line Information					
2210D	SVC		S	Service Line Information			Use to request status information about a service line		
		SVC01	R	Composite Medical Procedure Identifier					

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		SVC01-1	R	Product or Service ID qualifier		HC, NU, ID	Contains the procedure code of the adjudicated claim. If the adjudicated code is not known then SVC01 will contain the original submitted procedure code.	2	HC = HCPCS or CPT code, NU = Revenue Code, ID = ICD - Procedure code (rarely used)
		SVC01-2	R	Product Service ID	Service Identification Code		If the value in SVC01-1 is NU, then this element is an NUBC Revenue code. If a value is present here, then SVC04 is not used	48	084-085 - SD/MC has a gap relating to 5 digit procedure codes
		SVC01-3	S	Procedure Modifier			Required if submitted on the original claim service line	2	Gap in SD/MC
		SVC01-4	S	Procedure Modifier			Required if submitted on the original claim service line	2	Gap in SD/MC
		SVC01-5	S	Procedure Modifier			Required if submitted on the original claim service line	2	Gap in SD/MC
		SVC01-6	S	Procedure Modifier			Required if submitted on the original claim service line	2	Gap in SD/MC
		SVC01-7	NU	Description					

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		SVC02	R	Monetary Amount	Line Item Charge Amount		Original submitted charge	18	Gap in SD/MC as service line charges are not separated from claim charges
		SVC03	NU	Monetary Amount					
		SVC04	S	Product Service ID	Revenue Code			48	Revenue code here if another code is used in SVC01-2
		SVC05	NU	Quantity					
		SVC06	NU	Composite Medical Procedure Identifier					
		SVC07	S	Quantity	Original units of service count		These are the submitted units of service. The default is 1 unit. This element is required when the submitted units are greater than 1	15	090 - 092 Gap exists when units of service and units of time are different.
2220D	STC		R	Service Line Status Information			Required if Subscriber is the Patient		
		STC01	R	Health Care Claim Status					

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		STC01-1	R	Industry Code	Health Care Claim Status Category Code		Category Code. Use code source 507	30	Send status on service line adjudication - Gap as SD/MC doesn't differentiate service line from claim line
		STC01-2	R	Industry Code	Health Care Claim Status Code		Status Code. Use code source 508	30	Send status on service line adjudication - Gap as SD/MC doesn't differentiate service line from claim line
		STC01-3	S	Entity Identifier Code		Many codes in list	Further Modified the status code in STC01-2. Required if additional detail applicable to claim status is needed to clarify the status and the payer's system supports this level of detail.	3	Code list in IG - determine necessity for this information

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		STC02	R	Date	Status Information Effective Date		Effective Date of Status	8	Return date status determined - Gap
		STC03	NU	Action Code				2	
		STC04	R	Monetary Amount	Line Item Charge Amount		Amount of submitted charges	18	Return charges from line item on 837 - Gap as SD/MC doesn't differentiate line item from claim charges
		STC05	R	Monetary Amount	Line Item Provider Payment Amount		Use this element for the line item paid amount. This amount must be zero if the adjudication process is not complete. May change based on claims processing instructions, i.e.: splitting of claims.	18	Return payments from line items on 837 - Gap as SD/MC doesn't differentiate line item from claim charges
		STC06	NU	Date	Adjudication or Payment Date			8	

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		STC07	NU	Payment Method Code				3	
		STC08	NU	Date	Check issue or EFT Date			8	
		STC09	NU	Check Number	Check or EFT Trace Number			16	
		STC10	S	Health Care Claim Status			Use this element if a second claim status is needed		
		STC10-1	R	Industry Code	Health Care Claim Status Category Code		Category Code. Use code source 507	30	Use for additional claim status information
		STC10-2	R	Industry Code	Health Care Claim Status Code		Status Code. Use code source 508	30	Use for additional claim status information
		STC10-3	S	Entity Identifier Code		Many codes in list	Further Modified the status code in STC01-2. Required if additional detail applicable to claim status is needed to clarify the status and the payer's system supports this level of detail.	3	
		STC11	S	Health Care Claim Status			Use this element if a second claim status is needed		
		STC11-1	R	Industry Code	Health Care Claim Status Category Code		Category Code. Use code source 507	30	Use for additional claim status information

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		STC11-2	R	Industry Code	Health Care Claim Status Code		Status Code. Use code source 508	30	Use for additional claim status information
		STC11-3	S	Entity Identifier Code		Many codes in list	Further Modified the status code in STC01-2. Required if additional detail applicable to claim status is needed to clarify the status and the payer's system supports this level of detail.	3	
		STC12	NU	Free Form Text					
2220D	REF		S	Service Line Item Identification					
		REF01	R	Reference Identification Qualifier	Line Item Control Number	FJ	Use this segment if the subscriber is the patient, Required when available from the original claim. When the Information receiver is the provider, this is required when the number was assigned by the provider on the original claim.	3	LX from original claim - Gap
		REF02	R	Reference Identification	Line Item Control Number			30	LX number from original claim - Gap
		REF03	NU						
		REF04	NU						
2220D	DTP		R	Service Line Date					

Loop	Field	Segment	R/S	Loop or Segment Name	Field Description	Example Values	Use Notes	Max Field Size	Current SD/MC field
		DTP01	R	Date/Time Qualifier		472	Service	3	Send 472
		DTP02	R	Date Time Period Format Qualifier		RD8 Date Range	Range of dates expressed in format CCYYMMDD-CCYYMMDD, if the date is a single date of service, the begin date equals the end date	3	Send RD8
		DTP03	R	Date Time Period	Service Line Date			35	
2000E	HL			Dependent Level			Not used		
	SE		R	Transaction Set Trailer					
		SE01	R	Number of Included Segments				10	Count segments
		SE02	R	Transaction Set Control Number			Data value in SE02 must be identical to ST02	9	Repeat ST02 number

Appendix B. HIPAA External Code Sets

External Code Set Name	Source	Available From	Update Frequency
American Dental Association Codes	Current Dental Terminology (CDT) Manual	Salable Materials American Dental Association 211 East Chicago Avenue Chicago, IL 60611-2678 (800) 947-4746	Systematic review every 2-3 years
Claim Adjustment Reason Code	National Health Care Claim Payment/Advice Committee Bulletins	www.wpc-edi.com Washington Publishing Company 13309 Vandalia Drive Rockville, MD 20853-3313 (301) 949-9740	3x/year Loosely based on X12 trimester release
Claim Frequency Type Code	National Uniform Billing Data Element Specifications Type of Bill Position 3	National Uniform Billing Committee American Hospital Association 1 North Franklin Street Suite 2700 Chicago, IL 60606-4425 (312) 422-3000	As requested
CMS – formerly Health Care Financing Administration	Health Care Financing Administration (HCFA) Code Lists	www.cms.gov/medicare Health Care Financing Administration Office of Information Services Security and Standards Group Director, Division of Health Care Information Systems Standards N2-14-26 7500 Security Blvd. Baltimore, MD 21244-1850 CMS Gwynn Oak, MD 21207 (410) 786.3000	HCPCS updated quarterly
Countries, Currencies, and Funds	Codes for Representation of Names of Countries, ISO 3166-(Latest Release) Codes for Representation of Currencies and Funds, ISO 4217-(Latest Release)	American National Standards Institute 25 West 43rdStreet New York, NY 10036-7406 (212) 642-4900	Can be updated at any time. A systematic review occurs every 4-5 years
Current Procedural Terminology (CPT) Codes	Physicians' Current Procedural Terminology (CPT) Manual	Order Department American Medical Association 515 North State Street Chicago, IL 60610	Yearly

External Code Set Name	Source	Available From	Update Frequency
Diagnosis Related Group Number (DRG)	Federal Register and Health Insurance Manual 15 (HIM 15)	Superintendent of Documents U.S. Government Printing Office Washington, DC 20402	Unknown
FIPS-55 (Named Populated Places)	Named Populated Places, Primary County Divisions, and Other Locational Entities of the United States.	National Technical Information Service 5285 Port Royal Road Springfield, VA 22161	Unknown
Health Care Financing Administration Common Procedural Coding System	Health Care Finance Administration Common Procedural Coding System	www.hcfa.gov/medicare/hcpcs.htm Health Care Financing Administration Center for Health Plans and Providers CCPP/DCPC C5-08-27 7500 Security Boulevard Baltimore, MD 21244-1850	As requested
Health Care Claim Status Category Code	Health Care Claim Status Category Code	Washington Publishing Company http://www.wpc-edi.com 5284 Randolph Road Rockville, MD 20852-2116 (301) 949-9740	3x/year Loosely based on X12 trimester release
Health Care Claim Status Code	Health Care Claim Status Code	Washington Publishing Company http://www.wpc-edi.com 5284 Randolph Road Rockville, MD 20852-2116 (301) 949-9740	3x/year Loosely based on X12 trimester release
Home Infusion EDI Coalition (HIEC) Product/Service Code List	Home Infusion EDI Coalition (HIEC) Coding System	HIEC Chairperson HIBCC (Health Industry Business Communications Council) 5110 North 40th Street Suite 250 Phoenix, AZ 85018	Unknown
International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure	International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)	U.S. National Center for Health Statistics Commission of Professional and Hospital Activities 1968 Green Road Ann Arbor, MI 48105	Unknown
International Organization for Standardization (Date and Time)	ISO 8601	American National Standards Institute 25 West 43rdStreet New York, NY 10036-7406 (212) 642-4900	Can be updated at any time. A systematic

External Code Set Name	Source	Available From	Update Frequency
			review occurs every 4-5 years
Languages	Code for the representation of names of languages (ISO 639)	American National Standards Institute 25 West 43rd Street New York, NY 10036-7406 (212) 642-4900	Can be updated at any time. A systematic review occurs every 4-5 years
Military Rank and Health Care Service Region	Military Health Systems Functional Area Manual - Data	Health Affairs Functional Data Administrator TRICARE Management Activity Information Management Technology and Reengineering, FI and DA 5111 Leesburg Pike Suite 810 Falls Church, VA 22041-3206	Unknown
National Association of Boards of Pharmacy Number	National Association of Boards of Pharmacy Database and Listings	National Council for Prescription Drug Programs 9243 East Raintree Drive Scottsdale, AZ 85260-7519 (480) 477-1000	Quarterly
National Association of Insurance Commissioners (NAIC) Code	National Association of Insurance Commissioners Company Code List Manual	National Association of Insurance Commission Publications Department 12th Street, Suite 1100 Kansas City, MO 64105-1925	Unknown
National Council for Prescription Drug Programs Reject/Payment Codes	National Council for Prescription Drug Programs Data Dictionary	NCPDP 9243 East Raintree Drive Scottsdale, AZ 85260-7519 (480) 477-1000	Quarterly
National Uniform Billing Committee (NUBC) Codes (Admission Type Code, Admission Source Code, Condition Code, Facility Type Code, HIPPS	National Uniform Billing Data Element Specifications	National Uniform Billing Committee American Hospital Association 1 North Franklin Street Suite 2700 Chicago, IL 60606-4425 (312) 422.3000	As requested

External Code Set Name	Source	Available From	Update Frequency
Rate Code, Occurrence Code, Occurrence Span Codes, Value Code, UB92 Bill Type Code, UB92 Revenue Code)			
National Drug Code	Blue Book, Price Alert, National Drug Data File	First Databank, The Hearst Corporation 1111 Bayhill Drive San Bruno, CA 94066	Unknown
National Drug Code by Format	Drug Establishment Registration and Listing Instruction Booklet	Federal Drug Listing Branch HFN-315 5600 Fishers Lane Rockville, MD 20857	As requested
NISO Z39.53 Language Code List	Code list for the representation of names of written languages (NISO Z39.53)	National Information Standards Organization Press P.O. 338 Oxon Hill, MD 20750-0338	As requested
Patient Status Code	National Uniform Billing Data Element Specifications	National Uniform Billing Committee American Hospital Association 840 Lake Shore Drive Chicago, IL 60697	As requested
Paygrade	Department of Defense Instruction (DODI) 1000.13 Sponsor Information - Block 7 Rank / Paygrade	Office of the Deputy Undersecretary of Defense for Program Integration Department of Defense 4000 Defense Pentagon Washington, DC 20301-4000	Unknown
Place of Service from Health Care Financing Administration Claim Form	Electronic Media Claims National Standard Format	www.hcfa.gov/medicare/poscode.htm Health Care Financing Administration Center for Health Plans and Providers 7500 Security Blvd. Baltimore, MD 21244-1850	As requested
Provider Taxonomy Codes	National Uniform Claim Committee (NUCC)	Washington Publishing Company http://www.wpc-edi.com 5284 Randolph Road Rockville, MD 20852-2116 (301) 949-9740	2x/year (Jan/July)
Remittance Remark Codes	Medicare Part A Specification for the ASC X12 835 (7/1/94) or	Washington Publishing Company http://www.wpc-edi.com or Health Care Financing Administration	3x/year Loosely based on X12 trimester

External Code Set Name	Source	Available From	Update Frequency
	Medicare Part B Specification for the ASC X12 835 (7/1/94) or National Standard Format Electronic Remittance Advice (Version 001.04)		release
States and Outlying Areas of the U.S.	National Zip Code and Post Office Directory	U.S. Postal Service National Information Data Center P.O. Box 2977 Washington, DC 20013 (202) 268-2000	As needed
Treatment Codes	Health Care Financing Administration Treatment Codes	Health Care Financing Administration Office of Financial Management Program Integrity Group C3-02-16 7500 Security Blvd. Baltimore, MD 21244-1850 CMS Gwynn Oak, MD 21207 (410) 786.3000	As requested
Universal Product Code	Publication series on Universal Product Code numbering system and usage.	Uniform Code Council, Inc. 7887 Washington Village Drive Dayton, OH 45459-3900 (937) 435-3870	Unknown
X12 Directories	X12.3 Data Element Dictionary X12.22 Segment Directory	Data Interchange Standards Association, Inc. (DISA) Suite 200 1800 Diagonal Road Alexandria, VA 22314-2852	As needed
Zip Code	National ZIP Code and Post Office Directory, Publication 65 The USPS Domestic Mail Manual	U.S Postal Service Washington, DC 20260 New Orders Superintendent of Documents	As needed

Appendix C. Internal Code Sets

Internal Code Set Name	Description
Action Code	Code indicating type of action
Ambulance Transport Code	Code indicating the type of ambulance transport
Ambulance Transport Reason Code	Code indicating the reason for ambulance transport
Benefits Assignment Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider
Benefit Status Code	The type of coverage under which benefits are paid
Certification Condition Indicator	Code indicating whether or not the condition codes apply to the patient or another entity
Certification Type Code	Code indicating the type of certification
Claim Adjustment Group Code	Code identifying the general category of payment adjustment
Claim Frequency Code	Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim
Claim or Encounter Identifier	Code indicating whether the transaction is a claim or reporting encounter information
Claim Filing Indicator Code	Code identifying type of claim
Claim Status Category Code	This is the Category code. Use code source 507
Claim Status Code	Code specifying the status of a claim submitted by the provider to the payer for processing
Code Category	Specifies the situation or category to which the code applies
Code List Qualifier Code	Code identifying a specific industry code list
Communication Number Qualifier	Code identifying the type of communication number such as telephone or fax
Condition Code	Code(s) used to identify condition(s) relating to this bill or relating to the patient
Contact Function Code	Code identifying the major duty or responsibility of the person or group named
Coverage Level Code	Code indicating the level of coverage being provided for this insured
Credit or Debit Flag Code	Code indicating whether amount is a credit or debit
Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format
Date Time Qualifier	Code specifying the type of date or time or both date and time
Diagnosis Type Code	Code identifying the type of diagnosis
Emergency Indicator	An indicator of whether or not emergency care was rendered in response to the sudden and unexpected onset of a medical condition, a severe injury, or an acute exacerbation of a chronic condition which was threatening to life, limb or sight, and which required emergency treatment

Employment Status Code	A code used to define the employment status of the individual covered by this insurance payer
Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual
Entity Type Qualifier	Code qualifying the type of entity
Explanation of Benefits Indicator	Indicator of whether a paper explanation of benefits (EOB) is requested
Facility Code Qualifier	Code identifying the type of facility referenced
Gender Code	A code indicating the gender of the patient or insured
Health Related Code	Code indicating a specific health situation
Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described
Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure
Hierarchical Structure Code	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set
Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67)
Individual Relationship Code	Code indicating the relationship between two individuals or entities
Insurance Line Code	Code identifying a group of insurance products
Insured Indicator	Indicates whether the insured is the subscriber or a dependent
Maintenance Reason Code	Code identifying reason for the maintenance change
Maintenance Type Code	Code identifying a specific type of item maintenance
Marital Status Code	Code defining the marital status of a person
Medicare Assignment Code	An indication, used by Medicare or other government programs, that the provider accepted assignment
Medicare Plan Code	Code identifying the Medicare Plan
Patient Status Code	A code indicating the patient's status at the date of admission, outpatient service, or start of care
Payer Responsibility Sequence Number	Code identifying the insurance carrier's level of responsibility for a payment of a claim
Payment Method Code	Code identifying the method for the movement of payment instructions
Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID
Provider Code	Code identifying the type of provider
Provider or Supplier Signature Indicator	An indicator that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office
Quantity Qualifier	Code specifying the type of quantity

Race or Ethnicity Code	Code indicating the racial or ethnic background of a person
Reference Identification Qualifier	Code qualifying the reference identification
Related Causes Code	Code identifying an accompanying cause of an illness, injury or an accident
Release of Information Code	Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations
Request Category Code	Code indicating a type of request
Time Period Qualifier	Code defining the type of time period
Trace Type Code	
Transaction Handling Code	This code designates whether and how the money and remittance information will be processed
Transaction Set Identifier Code	Code uniquely identifying a transaction set
Transaction Set Purpose Code	Code identifying purpose of transaction set
Unit or Basis for Measurement Code	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

Appendix D. Code Sets as They Appear in HIPAA Transactions

Transaction Code Sets

R = Required; R-IP = Required for Inpatient Claims; S = Situational, but required in many or most situations.

	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Action Code Code indicating type of action				R			S Required if the UMO has reviewed the request				
Ambulance Transport Code Code indicating the type of ambulance transport.	S Required for ambulance transportation					S Required for non-emergency ambulance transp.	S Required for non-emergency ambulance transp.				
Ambulance Transport Reason Code Code indicating the reason for ambulance transport.	S Required for ambulance transportation					S Required for non-emergency ambulance transp.	S Required if UMO auth. Specific transport criteria				

Transaction Code Sets

R = Required; R-IP = Required for Inpatient Claims; S = Situational, but required in many or most situations.

	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Admission Source Code Code indicating the source of this admission.		R -IP & Medicare OP				S	S Required if sent in the request				
Admission Type Code Code indicating the priority of this admission.		R -IP				R-IP	S Required if sent in the request				
Benefits Assignment Certification Indicator A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.	R	R									
Benefit Status Code The type of coverage under which benefits are paid.				R							
Certification Condition Indicator Code indicating whether or not the condition codes apply to the patient or another entity.	S	S				S Required when needed to justify med. necessity					

Transaction Code Sets

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Certification Type Code Code indicating the type of certification	S Required under specific conditions (e.g. home health, ambulance – See IGs	S Required under specific conditions (e.g. home health, ambulance – See IGs				R	R				
Claim Adjustment Group Code Code identifying the general category of payment adjustment.	S Required if paid amount is unequal to billed amount	S Required if paid amount is unequal to billed amount	S Required if paid amount is unequal to billed amount								
Claim Adjustment Reason Code Code that indicates the reason for the adjustment.	S Required if paid amount is unequal to billed amount	S Required if paid amount is unequal to billed amount	S Required if paid amount is unequal to billed		S Required if paid amount is unequal to billed amount						

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
			amount								
Claim Frequency Code Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim	R	R	S Required when present on original claim								
Claim or Encounter Identifier Code indicating whether the transaction is a claim or reporting encounter information.	R	R									
Claim Filing Indicator Code Code identifying type of claim	R	R	R								
Claim Status Category Code This is the Category code. Use code source 507.											R
Claim Status Code Code specifying the status of a claim submitted by the provider to the payer for processing.			R								R

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Code List Qualifier Code Code identifying a specific industry code list.	S Required when an industry code list is used	R				S Required when an industry code list is used	S Required when an industry code list is used	S	S		
Communication Number Qualifier Code identifying the type of communication number such as telephone or fax.	R	R	S Required if a contact communications number is to be transmitted.	S Required if a contact communications number is to be transmitted.	S Required if a contact communications number is to be transmitted.	S Required if a contact communications number is to be transmitted.	S Required if a contact communications number is to be transmitted.	S Required if a contact communications number is to be transmitted.	S Required if a contact communications number is to be transmitted.	S Required if a contact communications number is to be transmitted.	S Required if a contact communications number is to be transmitted.

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Condition Code Code(s) used to identify condition(s) relating to this bill or relating to the patient.	S Required when condition information applies to the claim or encounter, such as ambulance, home health, spinal manipulation, or vision	S Required when condition information applies to the claim or encounter, such as ambulance, home health, spinal manipulation, or vision				S Required when condition information applies to the claim or encounter, such as ambulance, home health, spinal manipulation, or vision					
Contact Function Code Code identifying the major duty or responsibility of the person or group named.	R	R	S	S							

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Coverage Level Code Code indicating the level of coverage being provided for this insured				S Required when under the insurance contract between the sponsor and payer and allowed by federal and state regulations.							
Credit or Debit Flag Code Code indicating whether amount is a credit or debit			R		R						
Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	R	R		S	S	S	S	S	S	S	S

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Date Time Qualifier Code specifying the type of date or time or both date and time.	R-IP	R	S	S	S	S	S	S	S	S	S
Diagnosis Code Code identifying the diagnosis	R-except in non-health care service claims	R-unless for Christian Science		S-Use when enrolling disabled member		S	S-Required if sent in the request and used for decision				
Diagnosis Type Code Code identifying the type of diagnosis.	R-except in non-health care service claims					S	S-Required if sent in the request and used for decision				
Diagnosis Related Groups (DRG) 19DRG Information is required when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer.		S-Required if IP Hosp is under contract with payer for DRG	S-Required if adjudication considers the DRG								

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Emergency Indicator An indicator of whether or not emergency care was rendered in response to the sudden and unexpected onset of a medical condition, a severe injury, or an acute exacerbation of a chronic condition	R										
Employment Status Code A code used to define the employment status of the individual covered by this insurance payer.				S-Required for subscriber							
Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	R	R	R	R	R	R	R	R	R	R	R
Entity Type Qualifier Code qualifying the type of entity	R	R	R	R	S	R	R	R	R	R	R
Explanation of Benefits Indicator Indicator of whether a paper explanation of benefits (EOB) is requested.		R									
Facility Code Qualifier Code identifying the type of facility referenced.		R				R	R				

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Facility Type Code Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format	R	R	S-Use when it's different from what was received in claim			R	R				
Gender Code A code indicating the gender of the patient or insured.	R	R		S-Required for new enrollments or changes to demographic information						R	R
Health Related Code Code indicating a specific health situation.				S-Required on initial enrollment when available							

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Hierarchical Child Code Code indicating if there are hierarchical child data segments subordinate to the level being described.	R	R				R	R	R	R	R	R
Hierarchical Level Code Code defining the characteristic of a level in a hierarchical structure.	R	R				R	R	R	R	R	R
Hierarchical Structure Code Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	R	R				R	R	R	R	R	R
Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67)	R	R	R	R	R	R	R	R	R	R	R
Individual Relationship Code Code indicating the relationship between two individuals or entities	R for the patient	R for the patient		R for the member		S Required if required by payer	S Required if available	R for the patient	R for the patient		

Transaction Code Sets

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Industry Code (Admitting Diagnosis/Patient Reason For Visit) The Admitting Diagnosis is required on all inpatient admission claims and encounters.		R -IP						S Use to identify Diagnosis codes and/or Facility Type as they relate to the information provided in the EQ segment.	S Use to identify Diagnosis codes and/or Facility Type as they relate to the information provided in the EB segment.		
Insurance Line Code Code identifying a group of insurance products				S-Required when enrolling a new member or when adding, updating or							

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
				removing coverage from an existing member.							
Insured Indicator Indicates whether the insured is the subscriber or a dependent.				R		S-Use if necessary to convey insurance related information about the individual identified.	S-Use if necessary to convey insurance related information about the individual identified.	S-Use this segment if necessary to convey insurance related information about the individual identified	S-Use this segment if necessary to convey insurance related information about the individual identified		

Transaction Code Sets

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Language Code This data element should be sent if the sponsor is able to code the language identification.				S-To be used if the member's language is other than English							
Maintenance Reason Code Code identifying reason for the maintenance change				S - Use is recom-mended					S-Use when the subscriber identifying data in the response differs from the information in the request		

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Maintenance Type Code Code identifying a specific type of item maintenance				R					S-Use when the subscriber identifying data in the response differs from the information in the request		
Marital Status Code Code defining the marital status of a person.				S-Required when under the insurance contract between the sponsor and payer and allowed							

Transaction Code Sets

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
				by federal and state regulations.							
Medicare Assignment Code An indication, used by Medicare or other government programs, that the provider accepted assignment.	R	S									
Medicare Plan Code Code identifying the Medicare Plan				S-Required for Medicare							
Occurrence Code A code defining a significant event relating to this bill that may affect payer processing; Required when occurrence information applies to the claim or encounter.		S-Required when occurrence information applies									

Transaction Code Sets

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
		to the claim or encounter.									
Patient Status Code A code indicating the patient's status at the date of admission, outpatient service, or start of care.		R -IP				R-IP	S-Required if sent				
Payer Responsibility Sequence Number Code identifying the insurance carrier's level of responsibility for a payment of a claim	R	R		S-Required when patient has additional insurance with similar benefits							
Payment Method Code Code identifying the method for the movement of payment instructions.			R		R						S-Used when claim has a dollar payment to the provider

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
											of service
Place of Service Codes The code that identifies where the service was performed.	R										
Postal Zone or ZIP Code	R										
Procedure Code Code identifying the procedure, product or service.	R	S-Required on all inpatient claims or encounters or OP or other claims that require procedure or drug info to be reported				S-Use to request authorization for a specific services and procedures.	S-Use to request authorization for a specific services and procedures.				

Transaction Code Sets

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Procedure Modifiers This identifies special circumstances related to the performance of the service, as defined by trading partners; This data element is required when the Provider needs to convey additional clarification for the associated procedure code	S-Required when the Provider needs to convey additional clarification for the associated procedure code.	S-Required when the Provider needs to convey additional clarification for the associated procedure code.	S-Required when applicable					S Required when inquiring on procedure eligibility and for further clarification	S-Required when the Provider needs to convey additional clarification for the associated procedure code.	S-Required if submitted on the original claim	S-Required if sent
Product or Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID	R	R	S	S		S		S	S	R	R
Provider Code Code identifying the type of provider.	S-Required if sending taxonomy code	S				S-Required if sending taxonomy code	S-Required if sending taxonomy code	S-Required if sending taxonomy code	S-Required if sending taxonomy code		

Transaction Code Sets

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Provider or Supplier Signature Indicator An indicator that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office.	R	R									
Provider Taxonomy Code Code designating the provider type, classification, and specialization.	S-Required if this is rendering provider and data impacts adjudication					S-Use when necessary to identify the provider's specialty	S-Use when necessary to identify the provider's specialty	S	S		
Quantity Qualifier Code specifying the type of quantity	S	S	S			S	S		S		

Transaction Code Sets

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Race or Ethnicity Code Code indicating the racial or ethnic background of a person.				S-Required when under the insurance contract between the sponsor and payer and allowed by federal and state regulations.							
Reference Identification Qualifier Code qualifying the reference identification	R	R	R	S	R	S	S	S	S	S	S
Related Causes Code Code identifying an accompanying cause of an illness, injury or an accident	S-Required if accident or work					S-Required if accident or work					

Transaction Code Sets

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
	related					related					
Release of Information Code Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations.	R	R				R					
Remark Code Remark codes are used in a remittance advice to relay informational messages that cannot be expressed with a claim adjustment reason code.	S- Use for Medicare adjudication information	S- Use for Medicare adjudication information	S-Use this segment to relay information remarks only								
Request Category Code Code indicating a type of request						R	R				
Revenue Codes										S- Required when qualifier for	S- Required when qualifier for

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
										service line info = "NU" (Revenue Code)	service line info = "NU" (Revenue Code)
Service Type Codes Code identifying the classification of service						S– Required if known	S– Required if use in deciding auth.	S-Use to identify the type of service in the benefit inquiry and response	S-Use to identify the type of service in the benefit inquiry and response		
State or Province Code	R										
Time Period Qualifier Code defining the type of time period.						S-Use to specify delivery pattern	S-Use to specify delivery pattern		S-Required when needed to qualify		
Trace Type Code Code identifying the type of reassociation, which needs to be performed.			R		R	S-Use to trace authorization	S-Use if sent in request	S-Use to trace member	S-Use if sent in request	R-if patient	R-if patient

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	Transactions										
Data Element Name	**837P**	**837I**	**835**	**834**	**820**	**278 REQ**	**278 RES**	**270**	**271**	**276**	**277**
Transaction Handling Code This code designates whether and how the money and remittance information will be processed.			R		R						
Transaction Set Identifier Code Code uniquely identifying a Transaction Set.	R	R	R	R	R	R	R	R	R	R	R
Transaction Set Purpose Code Code identifying purpose of transaction set.	R	R		R		R	R	R	R	R	R
Unit or Basis for Measurement Code Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.	R	R			S	S	S		S		
Value Codes A code that identifies data of a monetary nature that is necessary for processing this claim as required by the payer organization.		S- Required when value information applies to the claim or encounter.									

10. Gap Analysis and Requirements – Business Requirements Approval

We have reviewed the SD/MC Phase II Gap Analysis and Requirements – Business Requirements and hereby approve it.

____Signature on File_____ Date_____10/25/2004_____
Karen Redman, Project Director, ADP HIPAA Office

____Signature on File_____ Date_____10/15/2004_____
Julie Baltazar, Chief, DMH Office of HIPAA Compliance

____Signature on File_____ Date_____11/15/04_____
Russ Hart, Chief, PSD OHC Technology Section